

## 7550 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>A-A</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAY RIDGE</b>		c. LENGTH OF STAY IN 1b <b>30 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAY RIDGE, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NONE</b>				d. STREET ADDRESS <b>118 RIVER DR.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>MAE</b> Last <b>BALDWIN</b>				4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 29, 1864</b>		9. AGE (In years last birthday) <b>93</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elias Travers</b>				14. MOTHER'S MAIDEN NAME <b>MARY FINLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>WM S. COATES. SAME.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST WITH</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>WIDESPREAD METASTASES.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/19</b> , 19 <b>58</b> , to <b>7/5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/5</b> , 19 <b>58</b> , and that death occurred at <b>9:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 CATHEDRAL ST ANNAPOLIS, MD.</b> DATE SIGNED <b>7/5/58</b>							
ACTUAL SIGNATURE <b>Richard N. Peeler</b>				PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER ANNAPOLIS, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town or county) (State) <b>Bladensburg, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anthony Stanton</b>				ADDRESS <b>3831 La Grange Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Allen</b>	
				24c. REC'D BY REGISTRAR DATE <b>July 8 1958</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7551

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1 y 9m 8d</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>R.F.D. #2</b>									
3. NAME OF DECEASED (Type or print) First <b>Shedrick</b>		Middle <b>Baynard</b>		Last <b>Baynard</b>		4. DATE OF DEATH Month <b>7</b>		Day <b>22</b>		Year <b>1958</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1881</b>		9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Shed Baynard</b>		14. MOTHER'S MAIDEN NAME <b>Anne</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>Hospital Records</b>		Address					

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia and Hypostatic Pneumonia</b> DUE TO <b>Cerebrovascular Accident - Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Generalized and Cerebral Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>_____</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>		20f. (City or town) <b>_____</b>		(County) <b>_____</b>	
20f. (State) <b>_____</b>											
21. I certify that I attended the deceased from <b>10/14/1956</b> to <b>7/22/1958</b> , that I last saw the deceased alive on <b>7/22/1958</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>				ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>				DATE SIGNED <b>7/23/58</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				Crownsville State Hospital, Md.				7/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July 26/58</b>				22c. NAME OF CEMETERY OR CREMATORY <b>St Pauls</b>			
22d. LOCATION (City, town, or county) <b>Rural Denton</b>				(State) <b>Md</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Hugh Moore &amp; Son</b>				ADDRESS <b>Denton Md</b>				24. REC'D BY REGISTRAR <b>JUL 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Margarets Rd.</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Virgil Jesse Belair (alias Blair)</u>			4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1900</u>		9. AGE (In years last birthday) <u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Paintsville, Kentucky.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Daniel Belair</u>			14. MOTHER'S MAIDEN NAME <u>Lena Estep</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-05-2385</u>		17. INFORMANT Address <u>Mrs. Thelma Biensach (sister) Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(City or town)</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>7/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mr. Pleasant Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Gamber, Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Byers</u>		ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Edlich</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN TB <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> <b>83X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Anne Arundel General Hospital</b>			d. STREET ADDRESS <b>606 Woodlawn Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James W. BLYTH, II</b>			4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1952</b>		9. AGE (In years last birthday) <b>5</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Fort Belvoir, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Rodney A. BLYTH, Sr.</b>		
14. MOTHER'S MAIDEN NAME <b>Carol Marjorie Leffler</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Father</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowned, drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while bathing at Mayo Beach, Md.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mayo Beach</b>	
20f. (City or town) <b>A.A.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>[Signature]</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>July 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.P. Dues</i>		ADDRESS <b>2847 Wilson Blvd. Arlington 1, Va.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 27 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hume</i>	

DATE SIGNED  
**July 8, 1958**

STATE OF TEXAS  
COUNTY OF \_\_\_\_\_  
CITY OF \_\_\_\_\_

BEFORE ME, the undersigned authority, on this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

My commission expires \_\_\_\_\_.

Notary Public in and for the State of Texas



## 7521 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOHIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 CHESAPEAKE AVE</u>		d. STREET ADDRESS <u>120 CHESAPEAKE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>MAY</u> Last <u>BOISSEAU</u>		4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM CHURCHILL</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. JAMES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ETHEL BOISSEAU</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 HOURS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> 19 <u>58</u> , to <u>13 MAY</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12 MAY</u> 19 <u>58</u> , and that death occurred at <u>507</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D.		ADDRESS (Street, city or town, State) <u>4600 Maple Ave</u> DATE SIGNED <u>7/14/58</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 17 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1925

5. Time of death: 10:30 AM

6. Place of death: Home

7. Cause of death: Heart Disease

8. Signature of physician: Dr. J. B. Smith

9. Signature of registrar: John Doe

10. Signature of informant: John Doe

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7552

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtis Bay</u> c. LENGTH OF STAY IN 1b <u>Few hour</u>		2. USUAL RESIDENCE (Where deceased lived. If institut. on, Residence before admission) <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Curtis Creek</u>		e. STREET ADDRESS <u>2 South Exeter St.</u>	
3. NAME OF DECEASED (Type or print) <u>Evelyn Lita Boston</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/46</u>
9. AGE (in years last birthday) <u>12</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending school.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Robert Boston (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Grace Bruce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Grace Boston (Mother)</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Went swimming and drowned in 20 feet of water.</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:45 p.m.</u> <u>7/29/58</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Curtis Creek</u>	20f. (City or town) (County) (State) <u>Curtis Bay A.A. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustavo H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustavo H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

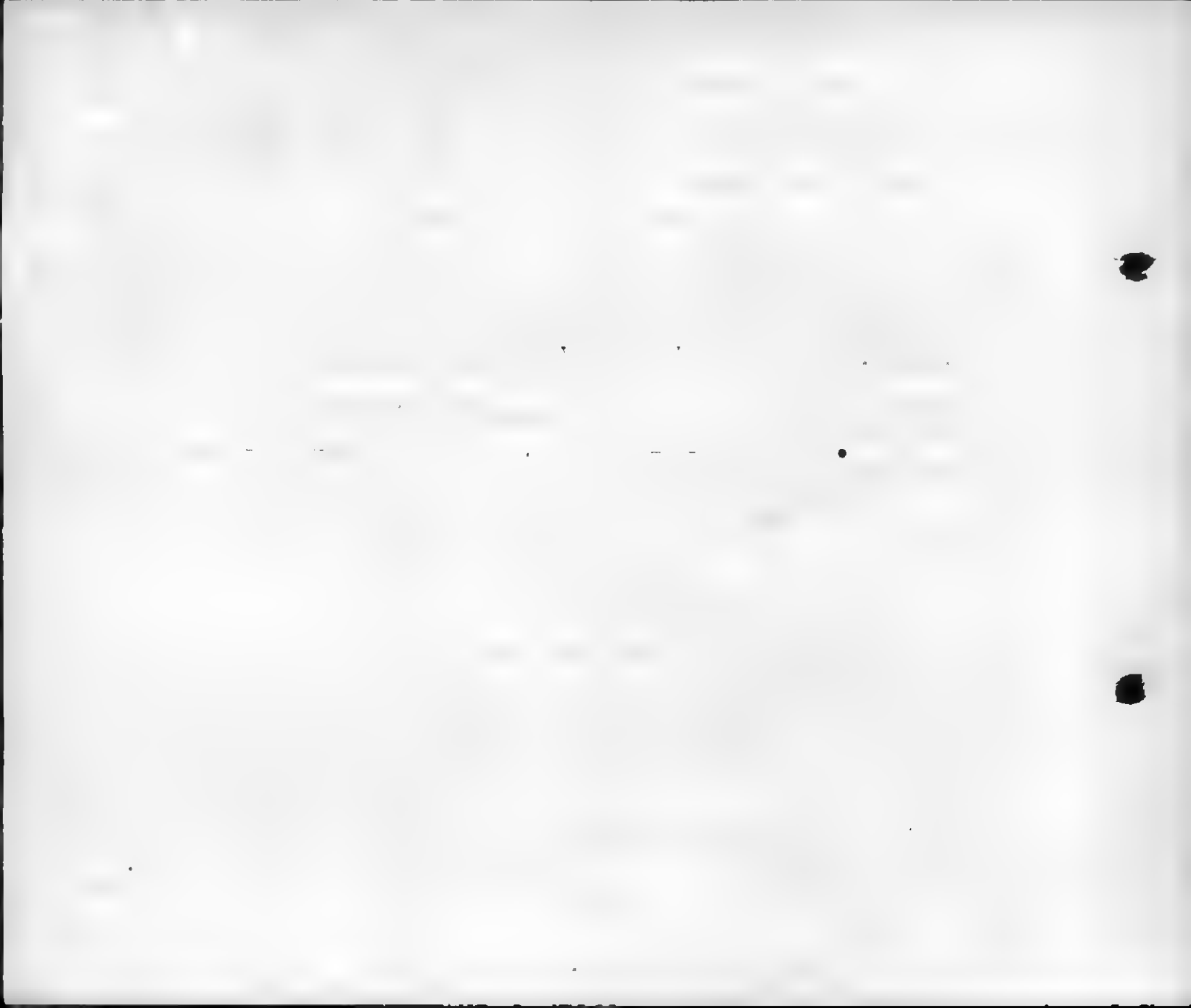
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>73 Shipwright Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES P BROCK</b>		4. DATE OF DEATH Month Day Year <b>JULY 7 19 58</b>		5. SEX <b>Mzle</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 10, 1899</b>		9. AGE (In years lost birthday) yrs <b>59 5/11</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Adm. Assit.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sect. of State, State of Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ernest N. Brock</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Brock Monahan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-1346</b>		17. INFORMANT Address <b>Mrs. Dorothy G. Brock- Wife- Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mediastinitis; Pleurisy &amp; Peritonitis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>Perforation of Esophagus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Jan 56</b> <b>July 7, 1958</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>July 5, 1958</b> , to <b>July 7, 1958</b> , that I last saw the deceased alive on <b>July 7, 1958</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>44 Southgate Ave., Annapolis, Md.</b>		DATE SIGNED <b>July 7, 1958</b>		ACTUAL SIGNATURE <b>Albert Anderson</b>		PHYSICIAN'S NAME (Type) <b>Albert Anderson</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07520

7553

Items 1, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Severn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>BROOKS</u> Last <u>BROOKS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Unknown</u>	8. DATE OF BIRTH <u>Mar. 19, 1905</u>
9. AGE (in years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>217-34-2018</u>	
17. INFORMANT <u>Mrs. Elliott, Odenton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to Manual Strangulation with Fractures of both Thyroid Cornua</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Assaulted and Strangled</u>	
20c. TIME OF INJURY Month, Day, Year <u>1.30</u> <u>6/27/</u> <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>woods</u>	20f. (City or town) (County) (State) <u>Odenton</u> <u>Anne Arundel</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/3/58</u>	
NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>	
22b. DATE THEREOF <u>July 6, 1958</u>	22c. LOCATION (City, town, or county) (State) <u>Friendship</u> <u>Anne Arundel</u> <u>Cs, Md</u>	23. FUNERAL DIRECTOR'S SIGNATURE <u>B. G. Harkness &amp; Son - Mutual, Ind.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

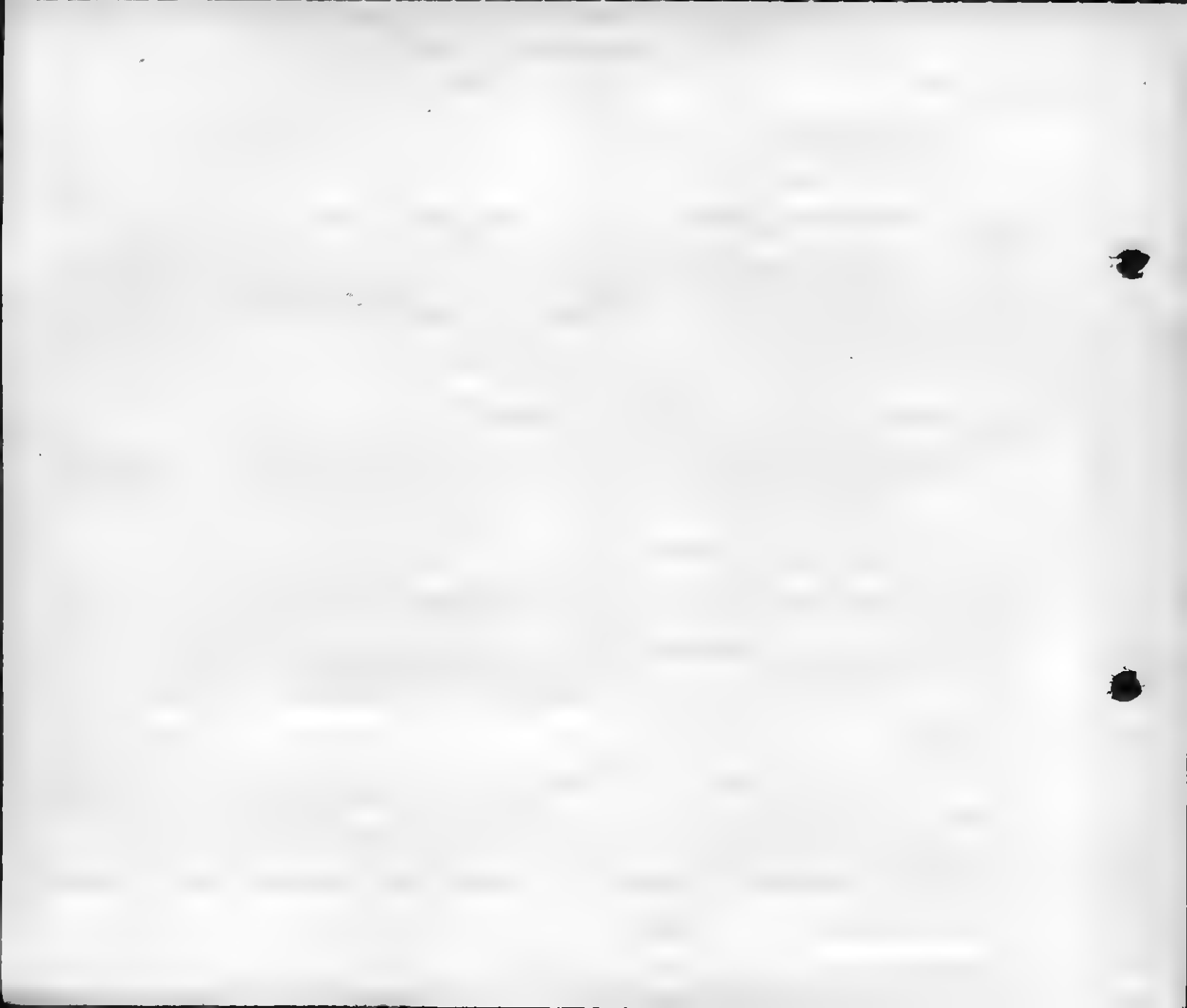
7554

CERTIFICATE OF DEATH

07521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewater Md.</u>		d. STREET ADDRESS <u>Edgewater Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Brown</u> Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brown</u>		14. MOTHER'S MAIDEN NAME <u>Harrietta Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>110</u>	
17. INFORMANT <u>Cherie Brown</u> Address <u>Rt 3 Box 549 Edgewater Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular disease grade III</u> DUE TO (b) <u>1 1/2 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Glaucoma of left eye</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1958</u> to <u>July 16, 1958</u> that I last saw the deceased alive on <u>July 16, 1958</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110-CLAY ST. BALTIMORE, MD.</u> DATE SIGNED <u>7/16/58</u>			
ACTUAL SIGNATURE <u>Wm. Rees</u>		PHYSICIAN'S NAME (Type) <u>Wm. Rees</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-20-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Rees</u> ADDRESS <u>108 W. 1st St. Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. Rees</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7555

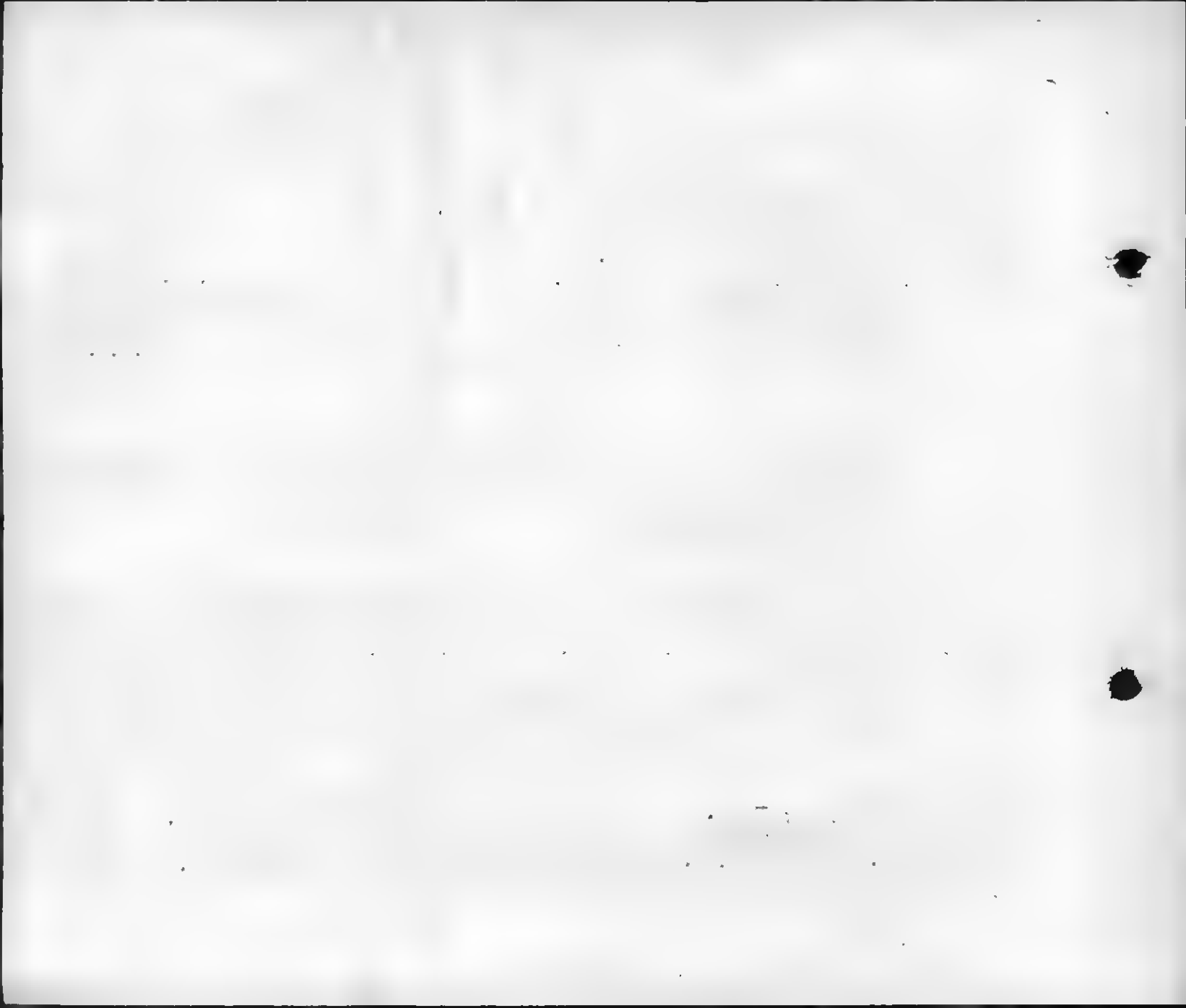
## CERTIFICATE OF DEATH

07522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>1 y 10m 6d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>2001 E. Biddle Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>W.</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>7</b> Day <b>31</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/25/09</b>	
9. AGE (In years last birthday) yrs <b>78</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO <b>Spanish American</b>			
17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Recurrent Bronchopneumonia</b> DUE TO <b>AHCVD &amp; Aortic Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Aortic Aneurysm</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubital ulcers and Chronic Brain Syndrome Associated with AHCVD</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>491X</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <b>56</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/25</b> , 19 <b>56</b> , to <b>7/31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/31</b> , 19 <b>58</b> , and that death occurred at <b>8:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>L. Benedict, M. D.</b> M. D.							
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				ADDRESS <b>Crownsville State Hospital, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cato. Ind.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Williams</b>				24a. REC'D BY REGISTRAR <b>1701-2341 Bond</b>			
24b. REGISTRAR'S SIGNATURE <b>W. H. Branch</b>				DATE <b>AUG 8 '58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7523 CERTIFICATE OF DEATH

Reg. Dist. No. 07523

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1974 Forrest Drive</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>30 CLAY ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>JONAS</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-78</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>ELIZABETH PURVIS</u>		Address <u>1974 Forrest Drive ANNAPOLIS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> DUE TO <u>Hypertensive Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Germinal Atresia</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>24y.</u> <u>15y.</u> <u>15y.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>7/2</u> , 19 <u>58</u> , to <u>7/24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>58</u> , and that death occurred on <u>  </u> , M, from the causes and on the date stated above. DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>37 Cabot Street Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>DR THEODORE H. JOHNSON</u>		<u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brower-Hill</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>		ADDRESS <u>ANNAPOLIS-Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7556

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

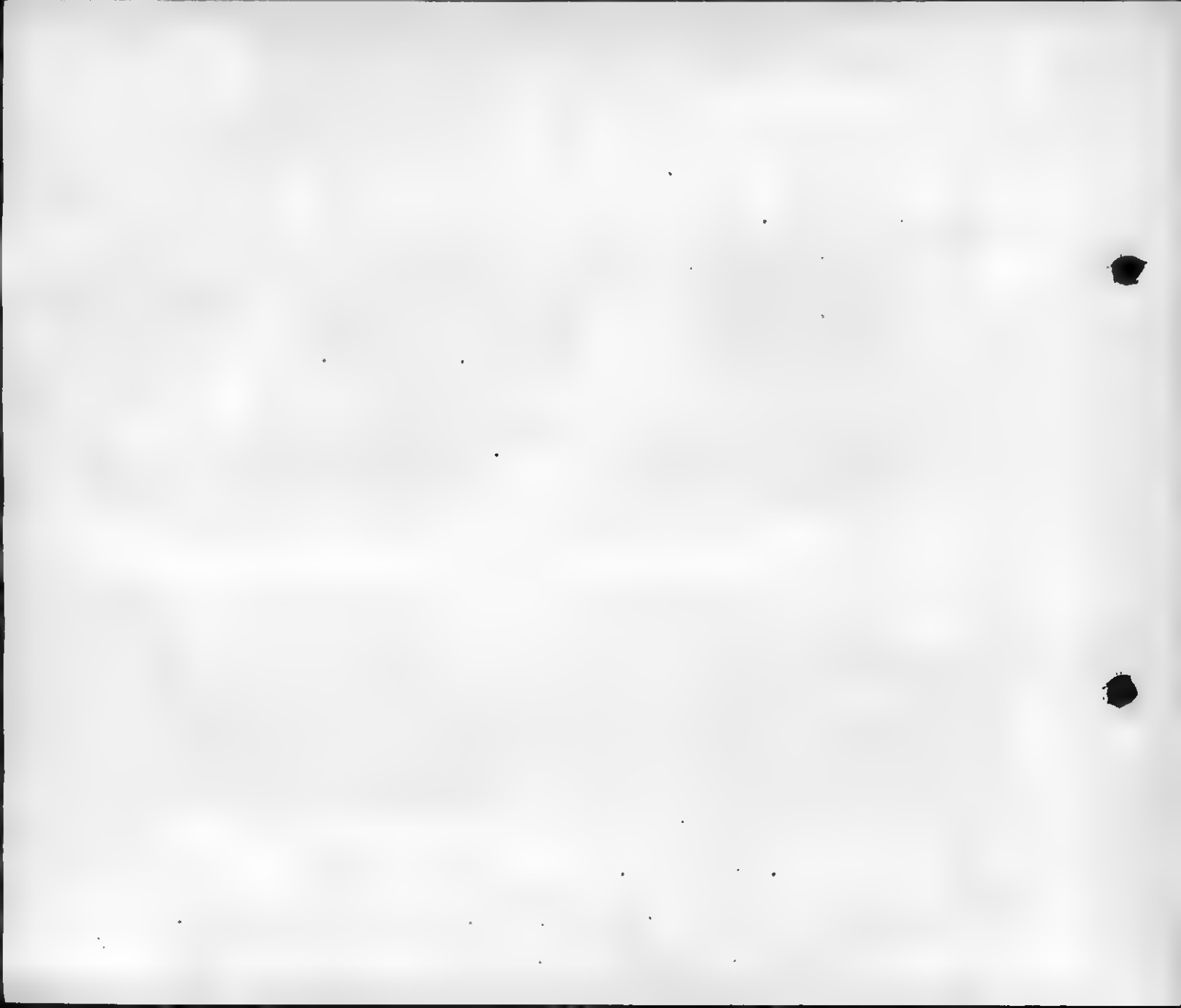
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
c. LENGTH OF STAY IN 1b <u>3 1/2</u> years		d. STREET ADDRESS <u>Box 355 Garland Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 355 Garland Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Victoria Irene Calvert</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/77</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired house keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. County, Md.</u>	
13. FATHER'S NAME <u>Joseph O Lopez</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Christine Calvert (daughter in law)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert M.D.</u>		DATE SIGNED <u>7/12/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 28 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 may be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7524 CERTIFICATE OF DEATH

Reg. Dist. 07525

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>191 Green St.</i>		d. STREET ADDRESS <i>191 Green</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frank Merriken Cantler</i>		4. DATE OF DEATH Month <i>7-</i> Day <i>15</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-1-1876</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith U.S.N.A.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Blacksmith</i>	
11. BIRTHPLACE (State or foreign country) <i>A.A. Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David R. Cantler</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>Yes Spanish American</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Elise Dell Cantler</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure with pulmonary</i> <i>352 X</i> DUE TO <i>bronchitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypostatic Pneumonia</i> 4 days (c) <i>Hemiplegia left complete</i> 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 10</i> , 1948, to <i>July 15</i> , 1958, that I last saw the deceased alive on <i>July 15</i> , 1958, and that death occurred at <i>4:05 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Oliver Purvis</i> M.D. <i>Annapolis, Md.</i> ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Dr. J. Oliver Purvis, 40 Franklin St., Annapolis, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-17-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Green Borne Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons Annapolis Md</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUL 21 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of 1

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



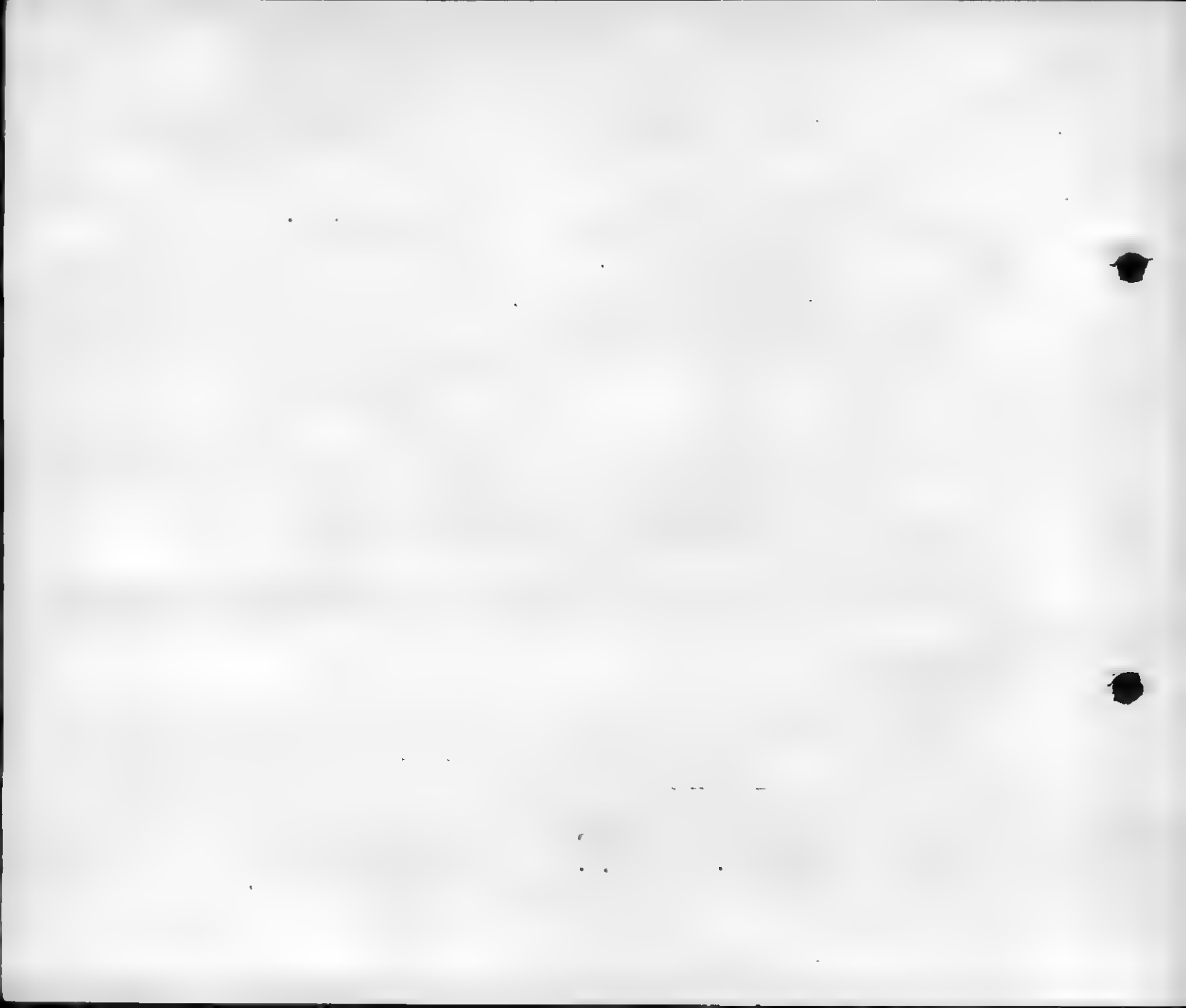
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Arnold</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Arnold</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>Box 369, Rt. #2</b>	
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>E.</b> Last <b>CARDWELL</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16, 1925</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min <b>33</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES W. AHALT</b>		14. MOTHER'S MAIDEN NAME <b>Annie M. Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Roger Cardwell</b> Address <b>Rt 2 Box 369 Arnold, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 350X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Ruptured Berry aneurysm</b> (c), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>o. m.</b> p. m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Petty</b>		DATE SIGNED <b>8/1/58</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lorettsville Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amelrose Inc. 1328 S. 13th St. Rd.</b>		24a. REC'D BY REGISTRAR <b>AUG 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas. S. Petty</b>		24c. REGISTRAR'S SIGNATURE	



## 7557 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Locust Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Duke</b> Last <b>Clark</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph I. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Margeret R. Pumphrey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-07-5798</b>		17. INFORMANT Address <b>Mrs Sarah Clark, Same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardio vascular diseases.</b> <b>445X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Over 5 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1st, 1958</b> to <b>7/17/58</b> , 19____ that I last saw the deceased alive on <b>7/15/58</b> , 19____, and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7/18/58</b>							
ACTUAL SIGNATURE <b>Eustace X. Pritchard</b> M.D.							
PHYSICIAN'S NAME (Type) <b>G. H. Faubert, M. D.</b>				<b>5 First Ave SE, Glen Burnie, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Kirkley</b> ADDRESS <b>Hopping and Kirkley, Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

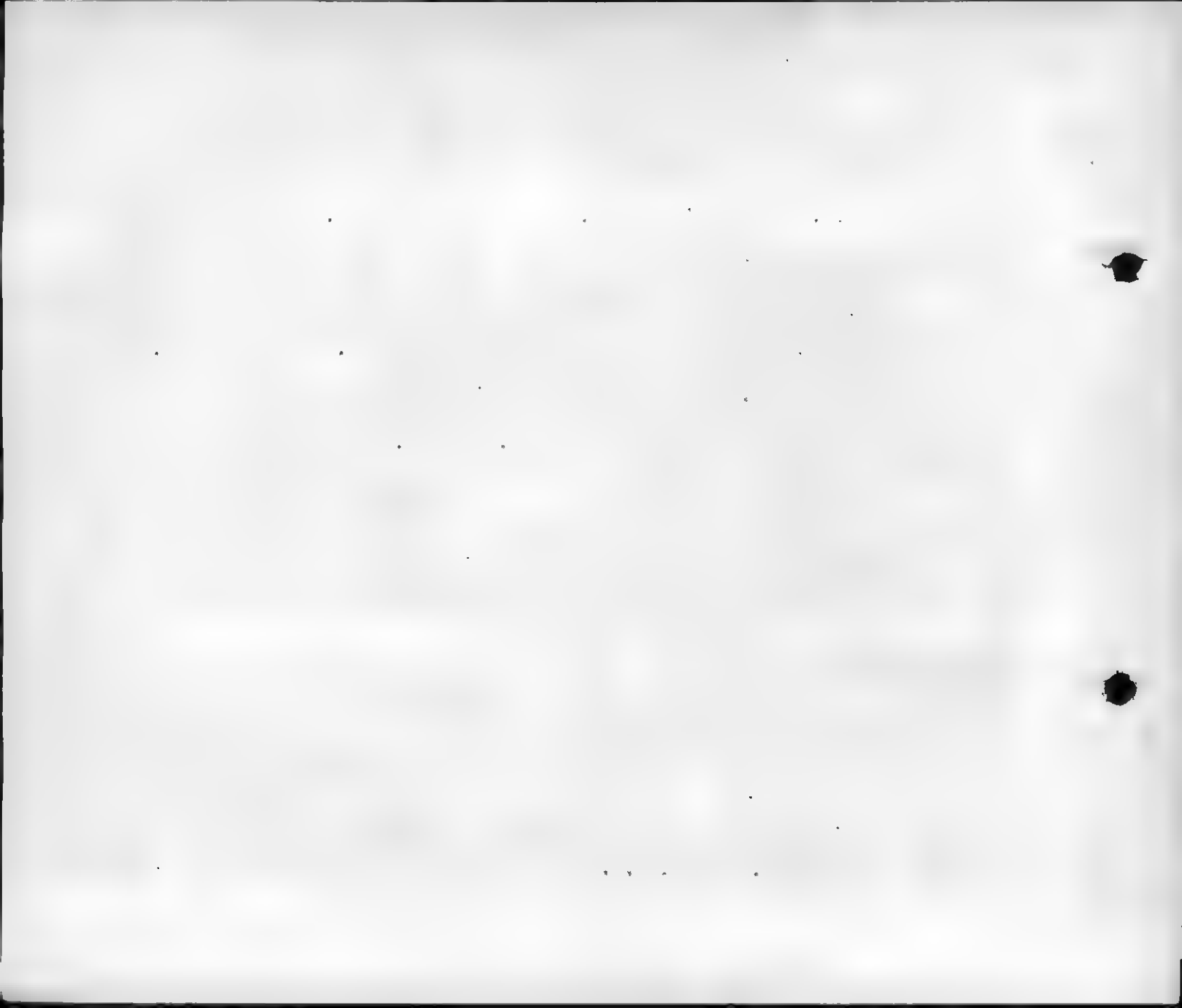
07528

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 25</u>	
c. LENGTH OF STAY IN 1b <u>Few minutes</u>		d. STREET ADDRESS <u>4209 Doris Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On the way to Dr. Sosnowski's Office.</u>		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Diane Margaret Connor</u>		4. DATE OF DEATH <u>July 31 1958</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/57</u>
9. AGE (In years last birthday) <u>9</u> yrs		10. IF UNDER 1 YEAR <u>22</u> Months <u>22</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>Harry E. Connor Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Schilling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Harry E. Connor (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u>			
DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. Fisher</u> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-4-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes 130 E. Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 4 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Fisher</u>	





7559

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>109 Sunset Drive</i>		d. STREET ADDRESS <i>109 Sunset Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Helen</i> First <i>Anna</i> Middle <i>Connor</i> Last		4. DATE OF DEATH Month <i>7</i> Day <i>9</i> Year <i>19 58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23, 1906</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Post office clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>51</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Weiler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Holley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-22-1402</i>	17. INFORMANT <i>Mr. James A. Connor,</i> Address <i>same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c) <i>hypertension</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 26, 1958</i> , to <i>July 9, 1958</i> , that I last saw the deceased alive on <i>July 9, 1958</i> , and that death occurred at <i>5:45</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles L. Ball, Jr.</i>		ADDRESS (Street, city or town, state) <i>Linthicum, Maryland</i> DATE SIGNED <i>7/10/58</i>	
PHYSICIAN'S NAME (Type) <i>Charles L. Ball, Jr.</i>		<i>Linthicum, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/14/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>A.A.Co. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Hartford Road #14</i>		24a. REC'D BY REGISTRAR <i>JUL 11 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Charles L. Ball, Jr.</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2 57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7526 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07530

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Mayo</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>A. A. General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>CURTIS</b> Last <b>CURTIS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1930</b>
9. AGE (In years last birthday) <b>28</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Mins <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
13. FATHER'S NAME <b>Walter Curtis Sp</b>		14. MOTHER'S MAIDEN NAME <b>Lena Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>216-14671</b>		16. SOCIAL SECURITY NO. <b>216-14671</b>	
17. INFORMANT <b>Mamie Curtis Mayo Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Hemorrhage</b> DUE TO <b>Stab Wounds of Left Neck.</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Stabbed during altercation.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>7/19/19 58</b> Hour <b>10:00</b> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. City or town <b>Annapolis</b> (County) <b>A. A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/19/58</b>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. P. P. 108 Wash St. Anna Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 23 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. P. P.</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtis Bay</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>Few hours</u>		d. STREET ADDRESS <u>905 Watson Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Curtis Creek</u>			
3. NAME OF DECEASED (Type or print) <u>Branda Mae Davis</u>		4. DATE OF DEATH <u>July 29th. 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/47</u>
9. AGE (in years last birthday) <u>10</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roanoke, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Doris Marie Jordan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Mr and Mrs. F.L. Davis (parents)</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Went swimming in Curtis Creek and drowned in 20 feet of water.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3.45 p.m. 7/29/58 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Curtis Creek</u>	20f. (City or town) <u>Curtis Bay, A.A.</u> (County) <u>Md.</u> (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) <u>Roanoke Va.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
ADDRESS <u>322 S. High ST</u>		DATE <u>AUG 21 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07531

7561

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1301 Myrtle Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Carroll</b> Middle <b>Edward</b> Last <b>Dillard</b>		4. DATE OF DEATH Month <b>7</b> Day <b>30</b> Year <b>1958</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1910</b>	9. AGE (In years last birthday) <b>48</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		
16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Edema with Convulsions</b> <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic and Acute Alcoholism</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the Liver with Advanced Jaundice</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 25, 1958</b> to <b>July 30, 1958</b> , that I last saw the deceased alive on <b>July 30, 1958</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b> <b>Crownsville State Hospital, Md.</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b> <b>Crownsville State Hospital, Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>8/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MOUNT CLAIR, N.J.</b>		22d. LOCATION (City, town, or county) (State) <b>MOUNT CLAIR, N.J.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel L. Brown &amp; Son</b> ADDRESS <b>108 W. MONTGOMERY ST BALTO 30 Md</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

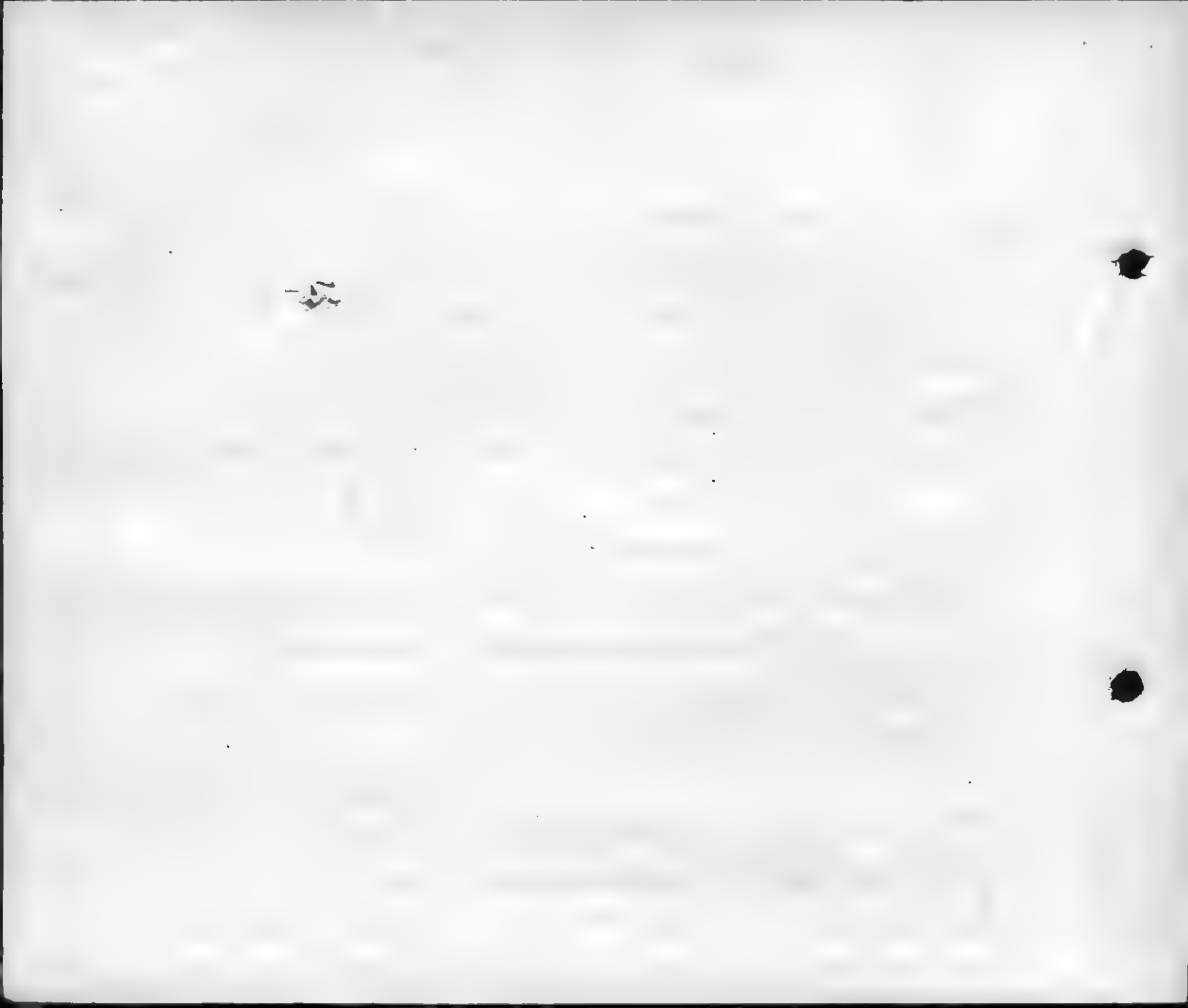
7562

## CERTIFICATE OF DEATH

07532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WINE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>15 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH (EDGEWATER P.B.)</u>		d. STREET ADDRESS <u>1975 SHORE DRIVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANNS NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ALBERT</u> Last <u>DUFFY</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1905</u>
9. AGE (in years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Schmeida Baking</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lawrence Duffy</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Clements</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>518-09-1162</u>		17. INFORMANT <u>Margaret R. Duffy</u> Address <u>1975 Shore Dr. Edgewater, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Paralysis - Residual</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 day</u> (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonian Syndrome</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>July</u> Day <u>15</u> Year <u>1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6</u>		20f. (City or town) <u>Edgewater</u> (County) <u>Anne Arundel</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>July 15, 1958</u> to <u>July 30, 1958</u> , that I last saw the deceased alive on <u>July 30, 1958</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKEY</u>		DATE SIGNED <u>JUL 30 1958</u>	
PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u>		ADDRESS <u>Opentown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-4-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co Inc. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W.W. Chamber</u>			



7563

## CERTIFICATE OF DEATH

07533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Junction</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Junction</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Myrtle Irene Eakin</u>		4. DATE OF DEATH <u>July 4 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Deland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Claudius Hall</u>		14. MOTHER'S MAIDEN NAME <u>Eva May Ireland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Patricia Eakin Annapolis Junction</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO <u>37</u> (c) <u>Chronic Coronary Disease</u> DUE TO <u>16</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/3</u> , 19 <u>58</u> , to <u>7/4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/1</u> , 19 <u>58</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Laurel, Md.</u> DATE SIGNED <u>7/4/58</u>			
ACTUAL SIGNATURE <u>J. M. Warren M.D.</u>		PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 7, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Caudle</u>		ADDRESS <u>Laurel, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jul 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Couch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## 7527 CERTIFICATE OF DEATH

Reg. D. 07534

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Annapolis Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>19 Calvert Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Petro</b> Middle <b>Eldridge, Jr.</b> Last <b>July</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1958</b>
9. AGE (In years last birthday) yrs <b>24</b> Months <b>24</b> Days <b>24</b> Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Petro Eldridge</b>		14. MOTHER'S M.A.D. NAME <b>Margaret McGhee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Mother</b>	
17. INFORMANT <b>19 Calvert St., Annapolis, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>cinaxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prenatal</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>7/29/58</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/27/58</b> to <b>7/29/58</b> , that I last saw the deceased alive on <b>7/29/58</b> , and that death occurred at <b>4:35</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Annapolis, Md.</b>	
ACTUAL SIGNATURE <b>James R. Martin</b> M.D.		DATE SIGNED <b>7/29/58</b>	
PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-1-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hall</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese #108 Wash. St. Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Reese</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7528 CERTIFICATE OF DEATH

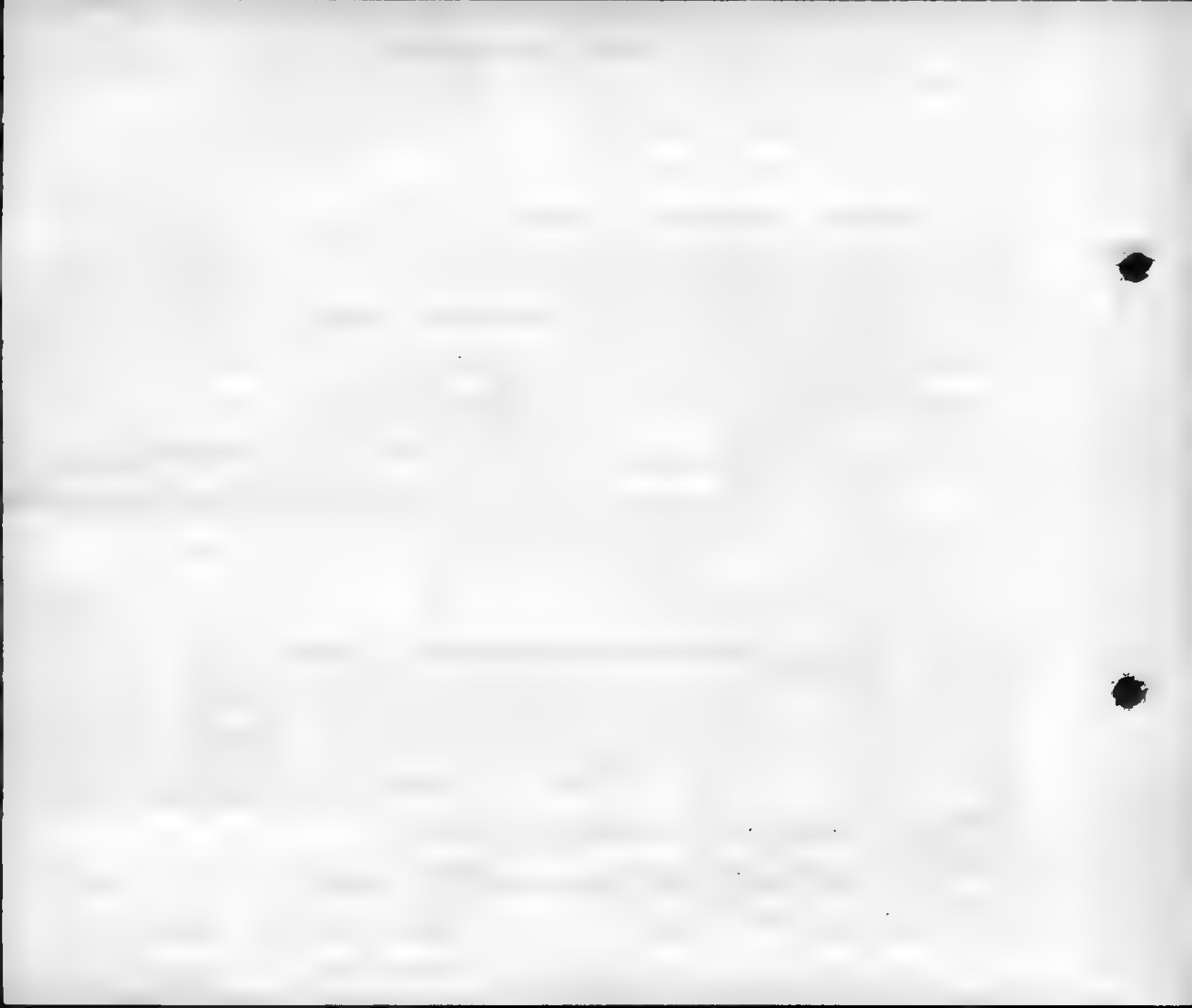
Reg. Dist. No. 07535

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 16 <i>11</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Homewood Convalescent Home</i>		d. STREET ADDRESS <i>1 Cheston Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Alice Loomis Gale</i>		4. DATE OF DEATH Month <i>7-</i> Day <i>1</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 9<sup>th</sup> 1872</i>
9. AGE (In years lost birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Erie Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Joel Porter Loomis</i>		14. MOTHER'S MAIDEN NAME <i>Kate Hoskinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Hamilton Gale II</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>177.2 Intra Abdominal Carcinoma</i> DUE TO <i>Progressive Inanition</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Arterio Sclerosis</i> DUE TO (c) <i>General Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several Mths</i> <i>Several Mths</i> <i>Yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 15</i> , 19 <i>58</i> , to <i>July 1</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>July 1</i> , 19 <i>58</i> , and that death occurred at <i>11:30</i> P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Annapolis Md</i> DATE SIGNED <i>7-25-58</i>	
ACTUAL SIGNATURE <i>Joel Porter Loomis</i> M.D.		PHYSICIAN'S NAME (Type) <i>J. OLIVER PURVIS</i> <i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>7-3-58</i>	<i>St Annes</i>	<i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 7 '58</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>David Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07536

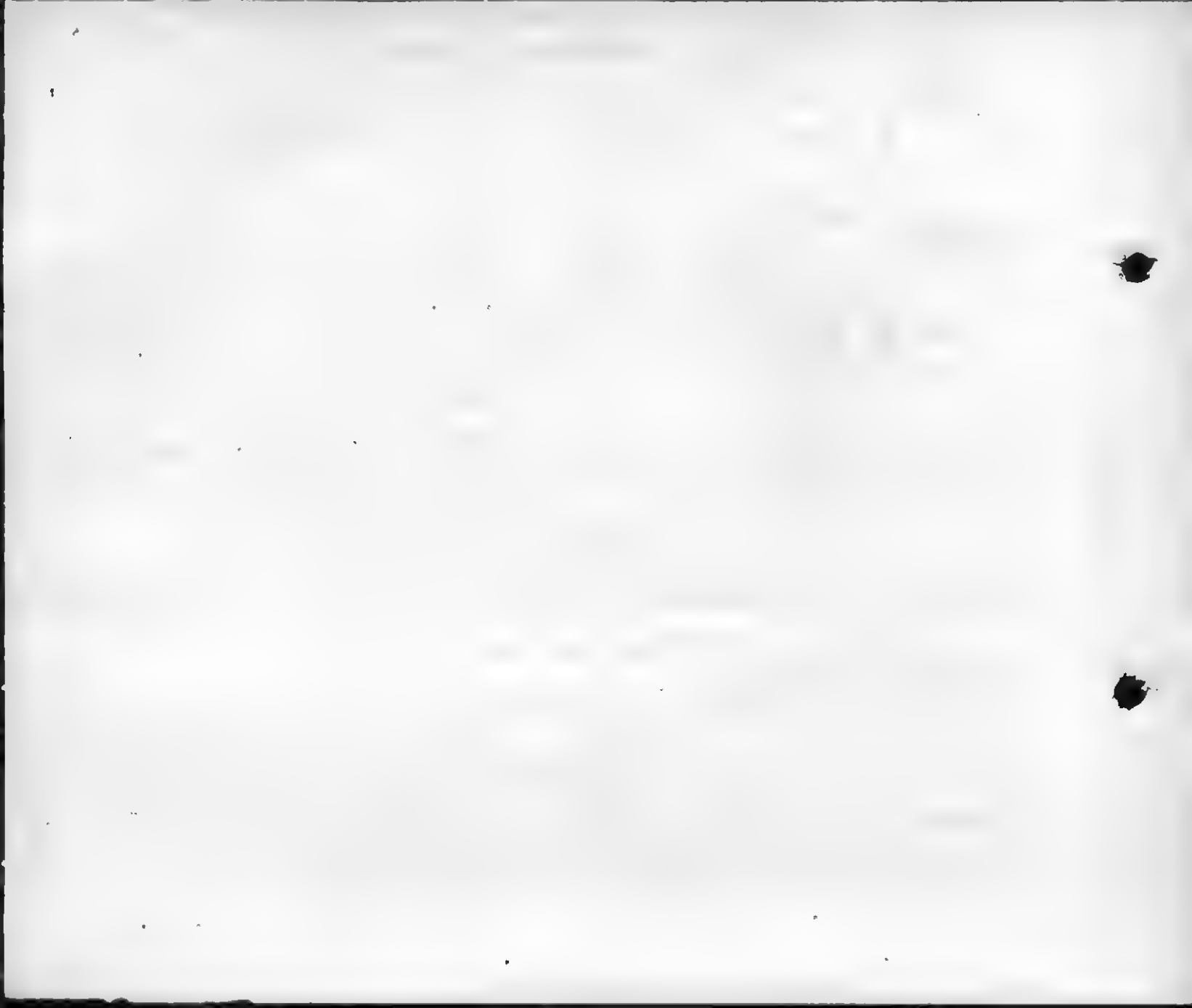
Reg. Dist. No.

7564

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Heath Road</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> d. STREET ADDRESS <u>505 Heath Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>RAYMOND</u> Last <u>GARDNER, SR.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 27, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Linth./Newell Corp. Maryland</u>			
13. FATHER'S NAME <u>John Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Baddle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212 03 3823</u>		17. INFORMANT <u>Mr. Arthur Gardner, Jr. Glen Burnie, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 2, 1958</u> to <u>July 30, 1958</u> , that I last saw the deceased alive on <u>July 30, 1958</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Schmold</u>				ADDRESS (Street, city or town, state) <u>2301 Annapolis Rd</u>			
PHYSICIAN'S NAME (Type) <u>Paul Schmold</u>				DATE SIGNED <u>8/1/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 2/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Doughton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on simple form filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

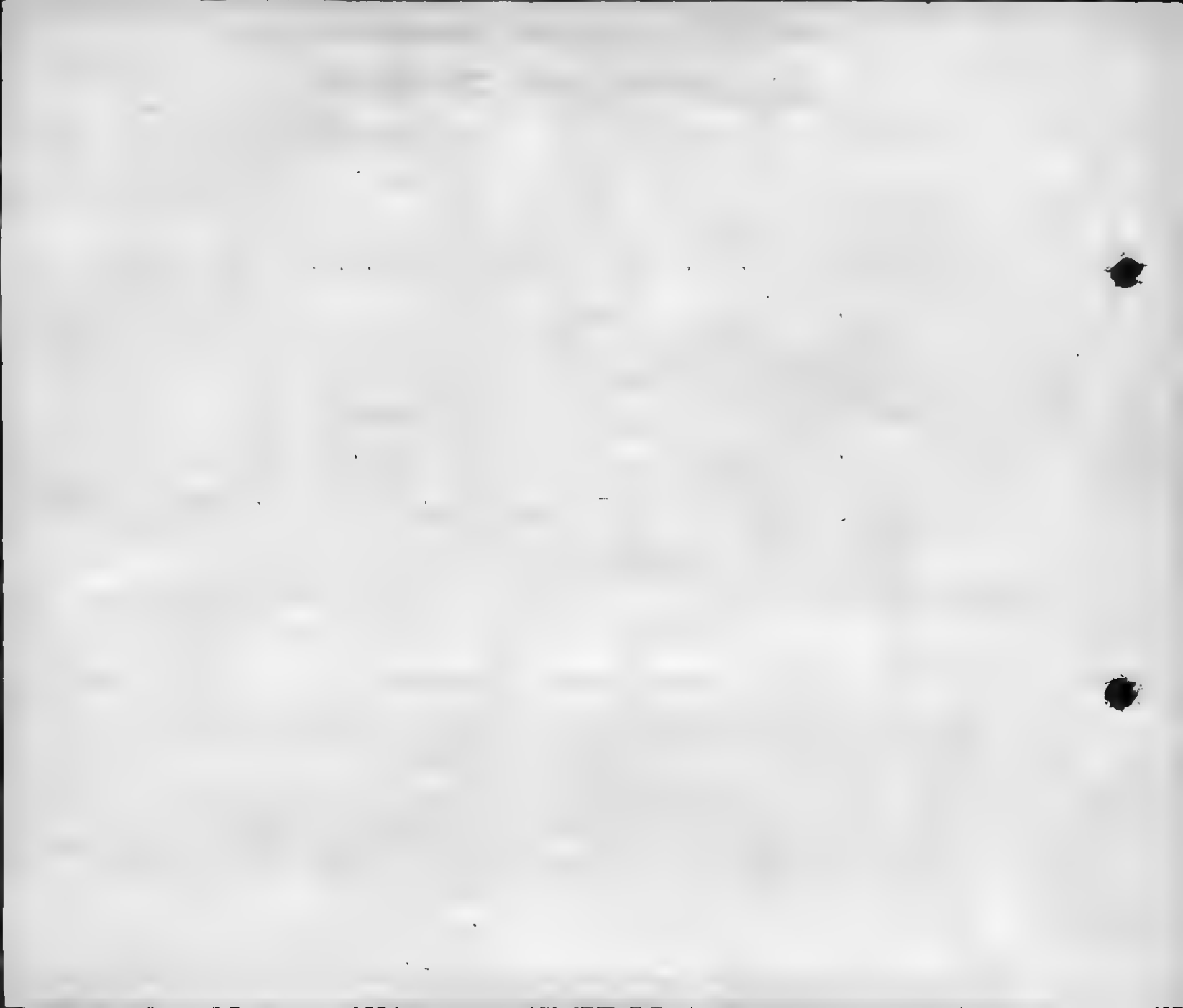
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 7565 CERTIFICATE OF DEATH

07537

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 902 R.F.D. #1</u>				STREET ADDRESS <u>Box 902 R.F.D. #1 Smith Trailer Park</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mr. Charles Edwin Gonder</u>				<b>4. DATE OF DEATH</b> (Month) <u>July</u> (Day) <u>16</u> (Year) <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 11, 1888</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George H. Gonder</u>				14. MOTHER'S MAIDEN NAME <u>Amelia E. Hessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-7505</u>		17. INFORMANT & ADDRESS <u>Mrs. Isabelle B. Gonder same</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Cerebral myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B) _____							
DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John C. Hedeman</u>		DATE THEREOF <u>7/19/58</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Jul 21 1958</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargord Road.</u>	



## 7566 CERTIFICATE OF DEATH

Reg. Dist. No.

Page 4

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## PHYSICIAN: The

**ATTENDING P**

HOSPITAL OF

VS A15 (4)  
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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

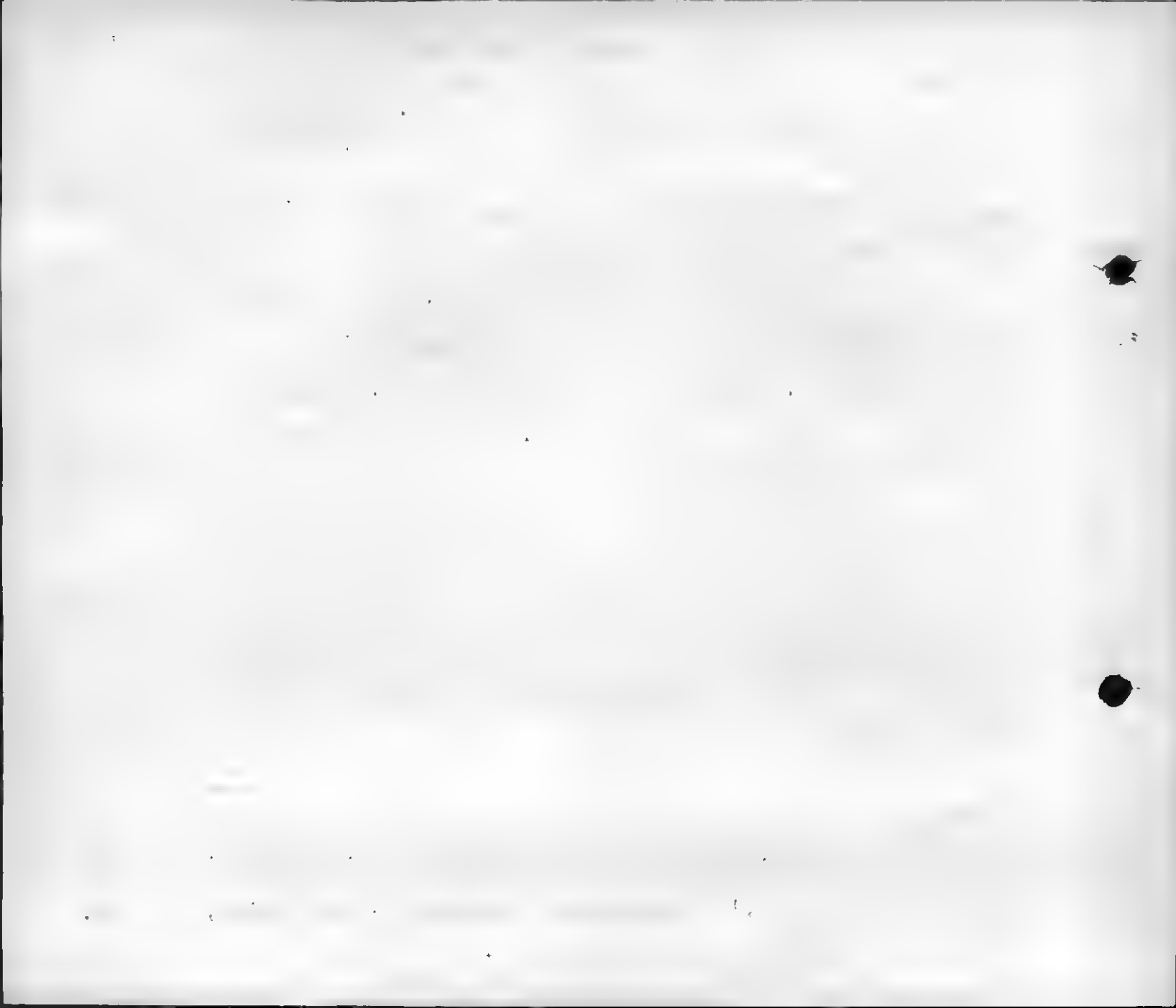
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>10 m 5 d</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2226 Poplar Grove</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Annie May</b>		Middle <b>Henderson</b>		Last <b>Green</b>		4. DATE OF DEATH Month <b>7</b>		Day <b>18</b>		Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 9, 1980</b>		9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months <b>7</b>		Days <b>18</b>		IF UNDER 24 HRS Hours <b>19</b> Min <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>George Anderson (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Green (Deceased)</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Hospital Records</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACVD (known since admission)</b> DUE TO (c) <b>Chronic Brain Syndrome and ACVD with senile deterioration</b>														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Past fractured hip joint</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>While at work</b>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>While at work</b>		20d. (City or town) <b>19</b>		(County) <b>19</b>		(State) <b>19</b>					
21. I certify that I attended the deceased from <b>9/13</b> , <b>19 57</b> , to <b>7/18/</b> , <b>19 58</b> , that I last saw the deceased alive on <b>7/18/</b> , <b>19 58</b> , and that death occurred at <b>7:25 A.M.</b> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>Hildegard Weissmann</b>		M.D. <b>Hildegard Weissmann</b>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>7/18/58</b>									
PHYSICIAN'S NAME (Type) <b>Hildegard Weissmann, M. D.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-21-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Sullivan</b>		ADDRESS <b>215 E. Baltimore St.</b>		24a. REC'D BY REGISTRAR <b>Jul 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>									



1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margeret</b> Middle <b>Susannah</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1886</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>22</b> Hours <b>00</b> Min <b>00</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		
13. FATHER'S NAME <b>Benjamin A. Hall</b>			14. MOTHER'S MAIDEN NAME <b>Anna D. Shaefer</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Harry Guinn, same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Transition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SENILITY</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	Month <b>19</b>	Day <b>19</b>	Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 1956</b> to <b>23 JULY 1958</b> , that I last saw the deceased alive on <b>23 JULY 1958</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Southgate Ave, Annapolis, Maryland</b> DATE SIGNED <b>JUL 28 '58</b>							
SIGNATURE <b>Edward S. Beck</b> M.D.							
NAME (Type) <b>Edward S. Beck</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 26, '58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 2, 57

FOR STATE  
HEALTH DEPT.

M

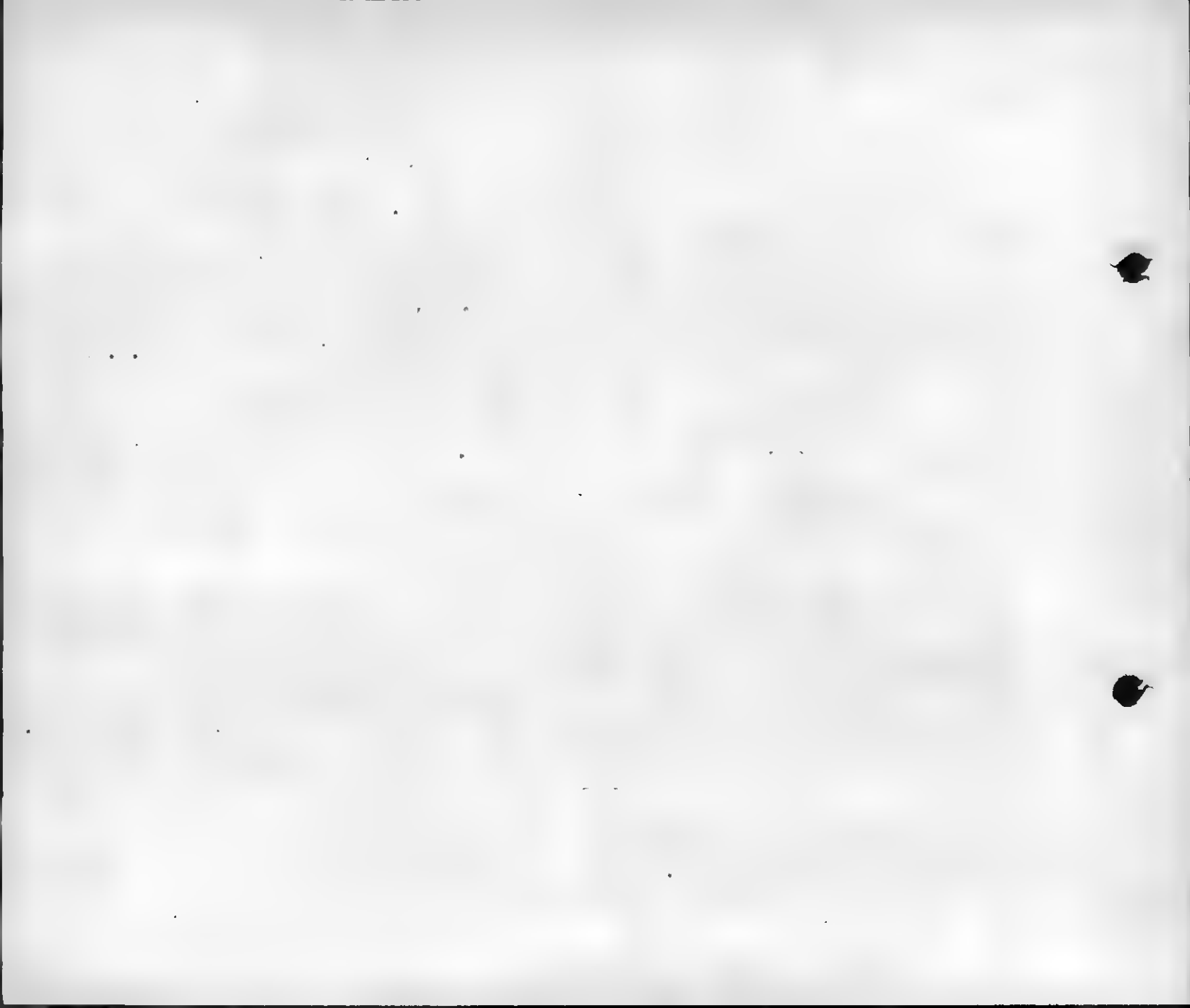
I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Off Pimhurst, Pasadena</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Bay</b>		d. STREET ADDRESS <b>110 N. Durham Street</b>	
3. NAME OF DECEASED (Type or print) First <b>VINCENT</b> Middle <b>MONROE</b> Last <b>HAMMONDS</b>		4. DATE OF DEATH Month <b>Found July</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1916</b>
9. AGE (In years last birthday) <b>41 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel Co</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Currance Hammonds</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Louk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>666-233-09-0623</b>	
17. INFORMANT <b>Howard H. Hammonds</b>		Address <b>928 S Ponca Street Balto</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Found drowned</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7/20</b> 19 <b>58</b> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) (County) (State) <b>Anne Arundel Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Sydney S. Katz</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Sydney S. Katz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>7/25/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 26, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wamsley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Bend West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dippel Brothers</b>		ADDRESS <b>1800 E Lombard Street</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. Leach</b>	



07541

## 7568 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

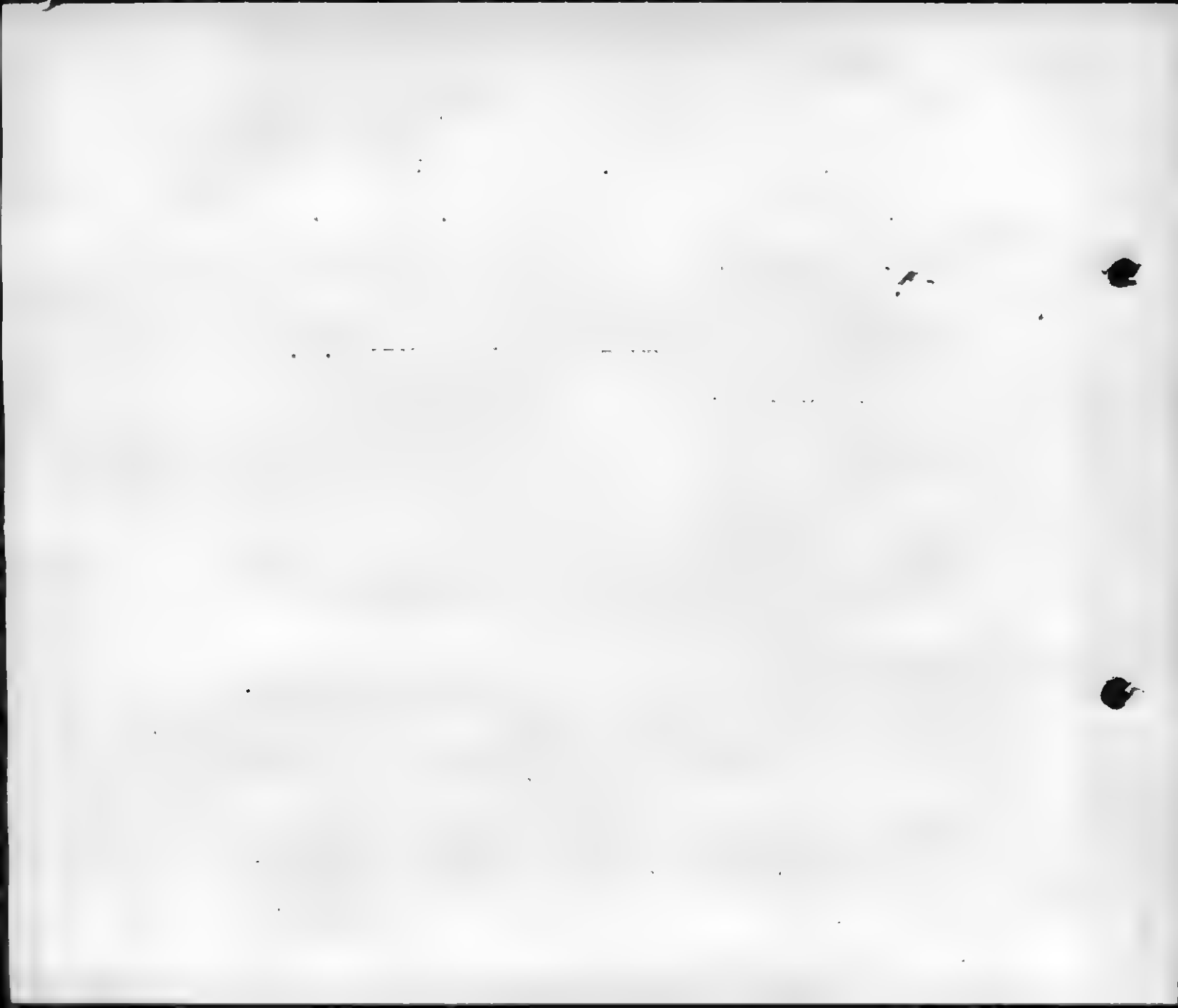
FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be ☐ a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bodkins Creek, Pasadena</b>		c. LENGTH OF STAY IN 1b <b>3 hrs.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Bay</b>				d. STREET ADDRESS <b>110 N. Durham St.</b>				e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Viola R. Hammonds</b>		First		Middle		Last		4. DATE OF DEATH Month Day Year <b>July 20 1958</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>?</b>		9. AGE (in years last birthday) <b>41</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hammondsville, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Schroeder Shrader</b>				14. MOTHER'S MAIDEN NAME <b>Lena Lloyd</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Howard Hammond (Son) 928 S Ponca Street</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>929.8 IMMEDIATE CAUSE (a) Accidental Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Jumped out the boat in the Chesapeake Bay.</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>9.30 p. m.</b>		Month, Day, Year <b>7/20/58 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>		20f. (City or town) (County) (State) <b>Pasadena A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>7/21/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 27 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wamsley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Bend West Va</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dinnel Brothers 1800 E Lombard Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7-32 221 7-4-58 et

07542

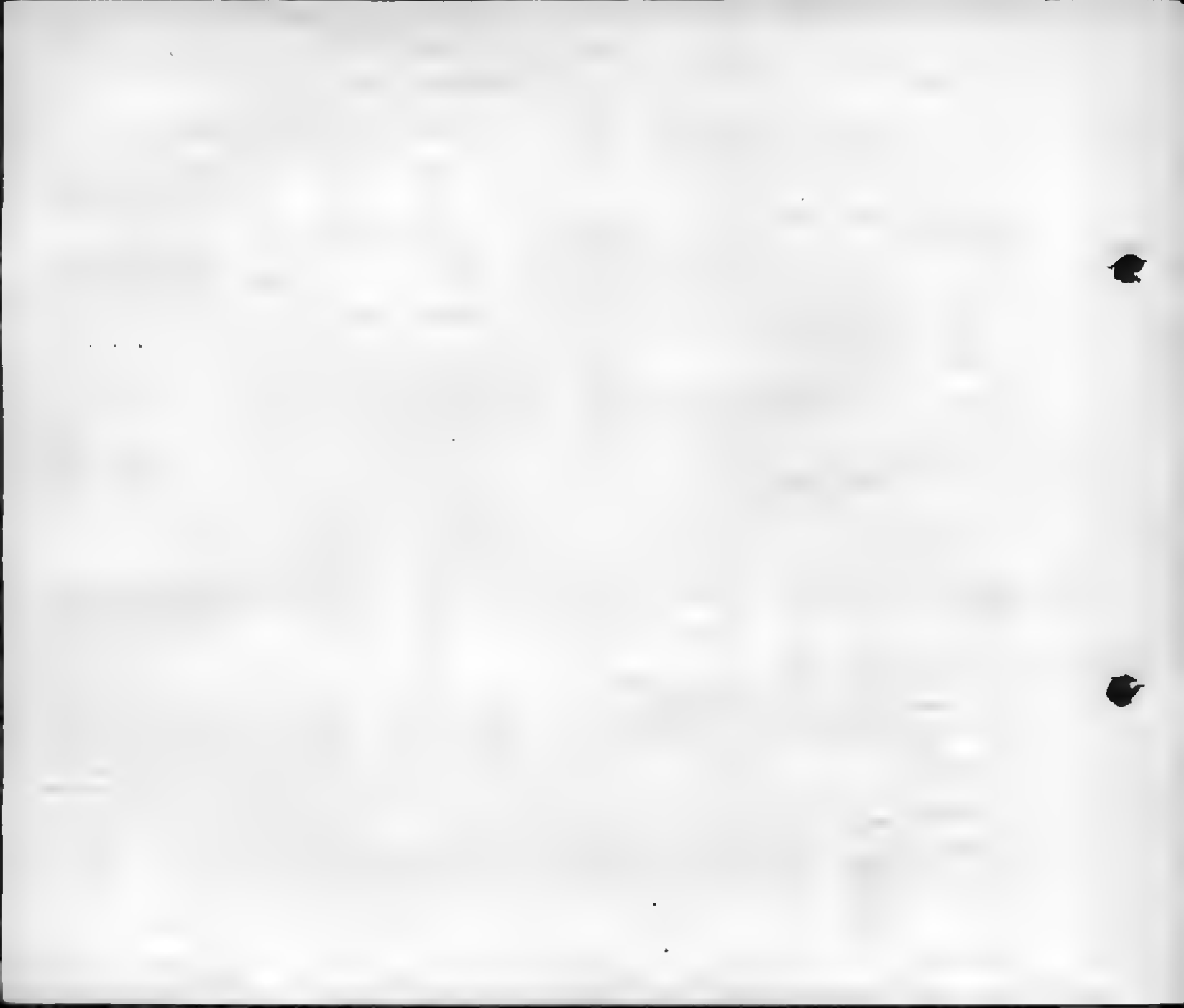
7569

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVA</u>				c. LENGTH OF STAY IN 1b <u>X</u> RIVA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riva Maryland</u>				e. STREET ADDRESS 1 <span style="float: right;">f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>John</u> Last <u>Harms</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1880</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool &amp; Di Maker</u>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carst n Harms</u>				14. MOTHER'S MAIDEN NAME <u>Henritta (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Carsten C. Harms, Riva, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1936</u> to <u>3 July 1958</u> , that I last saw the deceased alive on <u>2 July 1938</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Cook, Inc.</u> M.D. <u>4 Southgate Ave</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7/3/58</u>			
PHYSICIAN'S NAME (Type) <u>Asenapoles Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>7-7-58</u>		24b. REGISTRAR'S SIGNATURE <u>Asenapoles Md</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**07543**

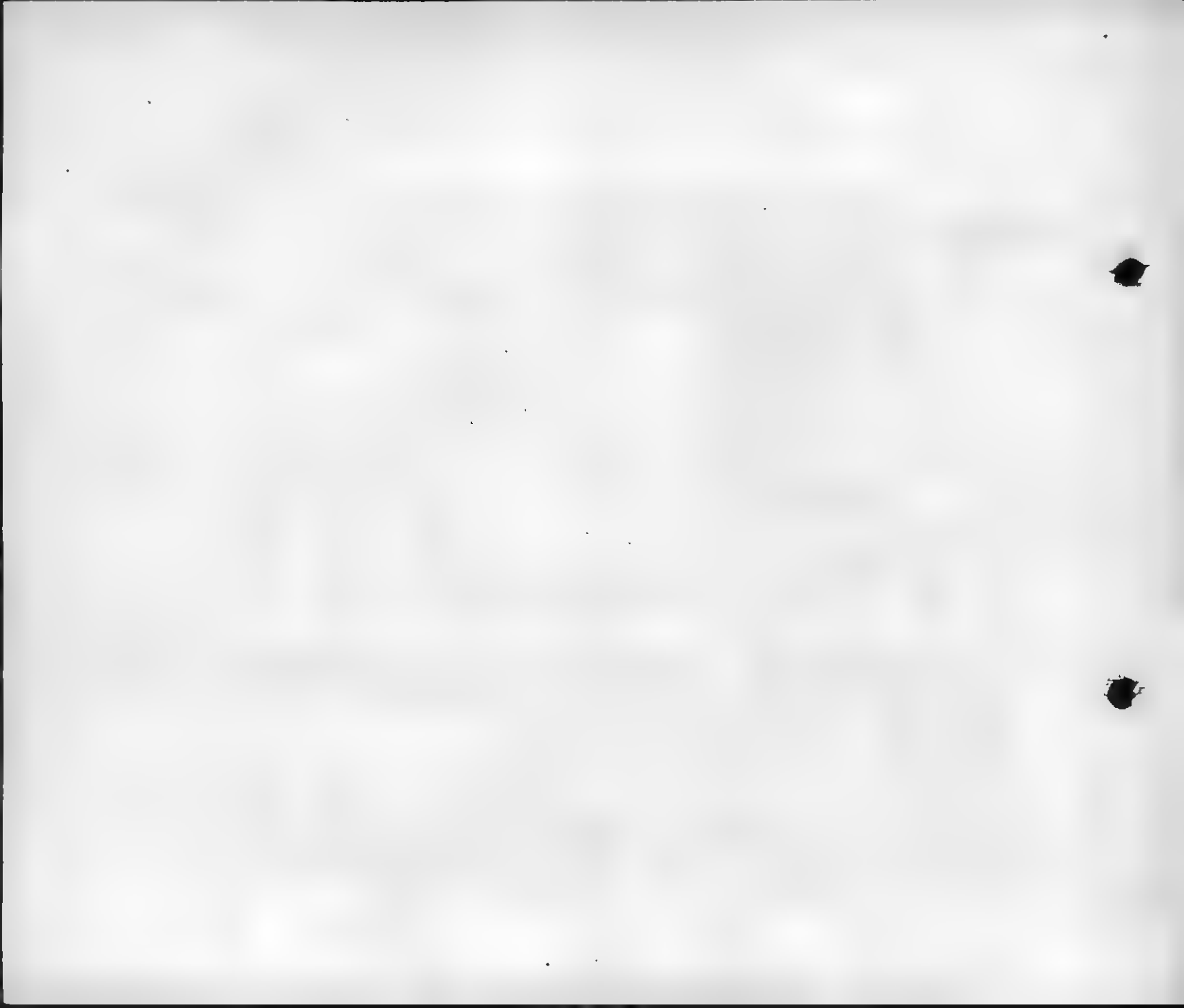
Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>Ad. Co. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. Co. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>267 Chestnut St. Eastport</u>		d. STREET ADDRESS <u>267 Chestnut St. Eastport</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Harris</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Enosley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Adella Sunnysville</u>		Address <u>52 Shaw St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>  </u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>  </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/21/58</u>	
22a. BURIAL, CREMATION REMOVAL (See 1)	22b. DATE THEREOF <u>7-22-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





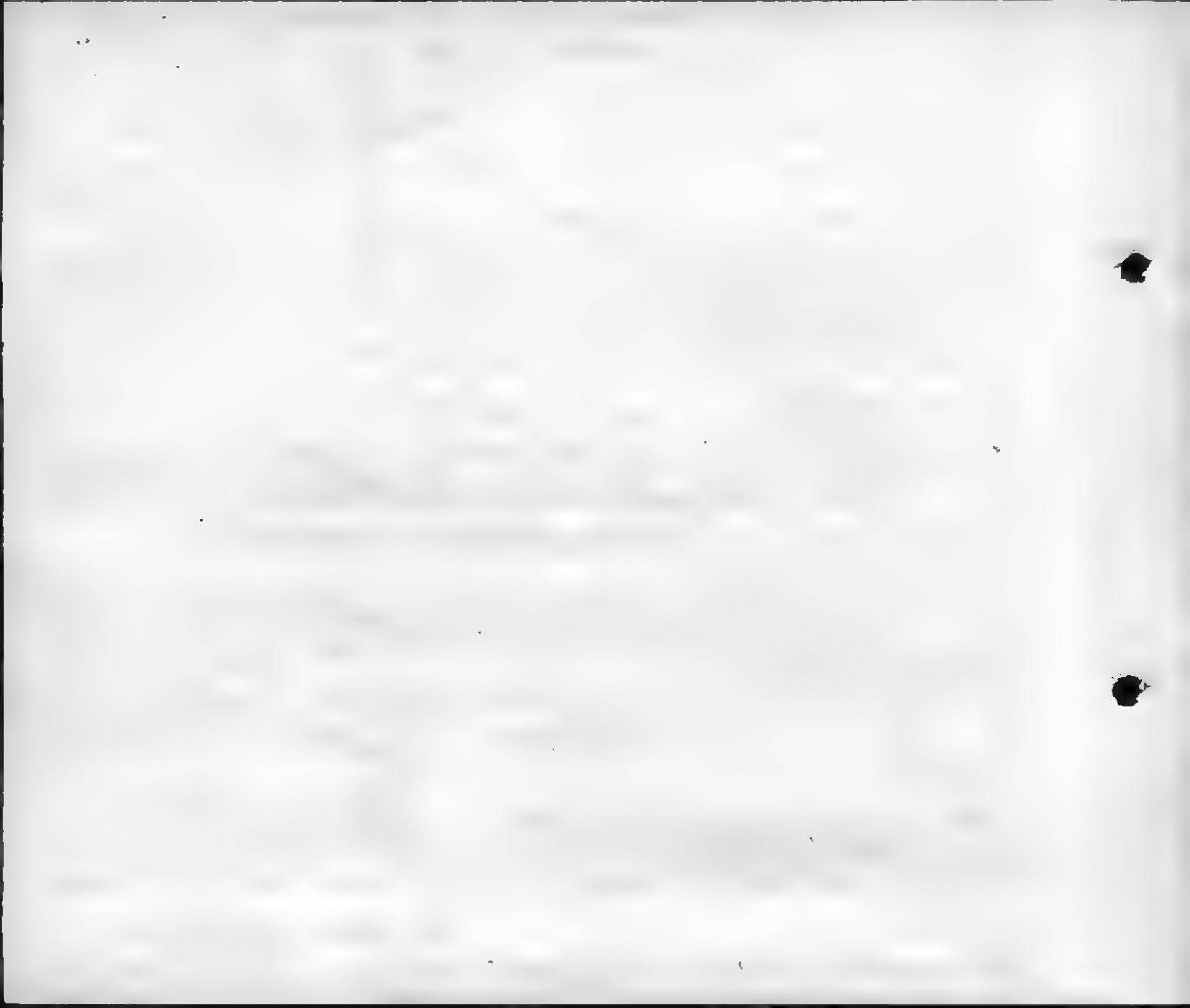
## 7570 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i> c. COUNTY <i>AA. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>millersville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Margate</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sanders' Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Susan</i> First <i>Headley</i> Middle Last		4. DATE OF DEATH Month <i>July</i> Day <i>23</i> Year <i>1958</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/25/1877</i>
9. AGE (In years, last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cliver Stott</i>		14. MOTHER'S MAIDEN NAME <i>Susan Bryant</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs Jean Williams</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 4342 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Myocardial Failure</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Older Arteriosclerosis Spine</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month <i>1</i> Day <i>19</i> Hour <i>—</i> m. <i>—</i> p.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>May 15, 1957</i> to <i>July 23, 1958</i> that I last saw the deceased alive on <i>July 23, 1958</i> and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.		DATE SIGNED <i>July 23, 1958</i>	
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKEY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-23-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Tombland Baptist Cem</i>	22d. LOCATION (City, town, or county) <i>Grovering</i> (State) <i>—</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley, Glen Burnie, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR <i>JUL 25 58</i> DATE	24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

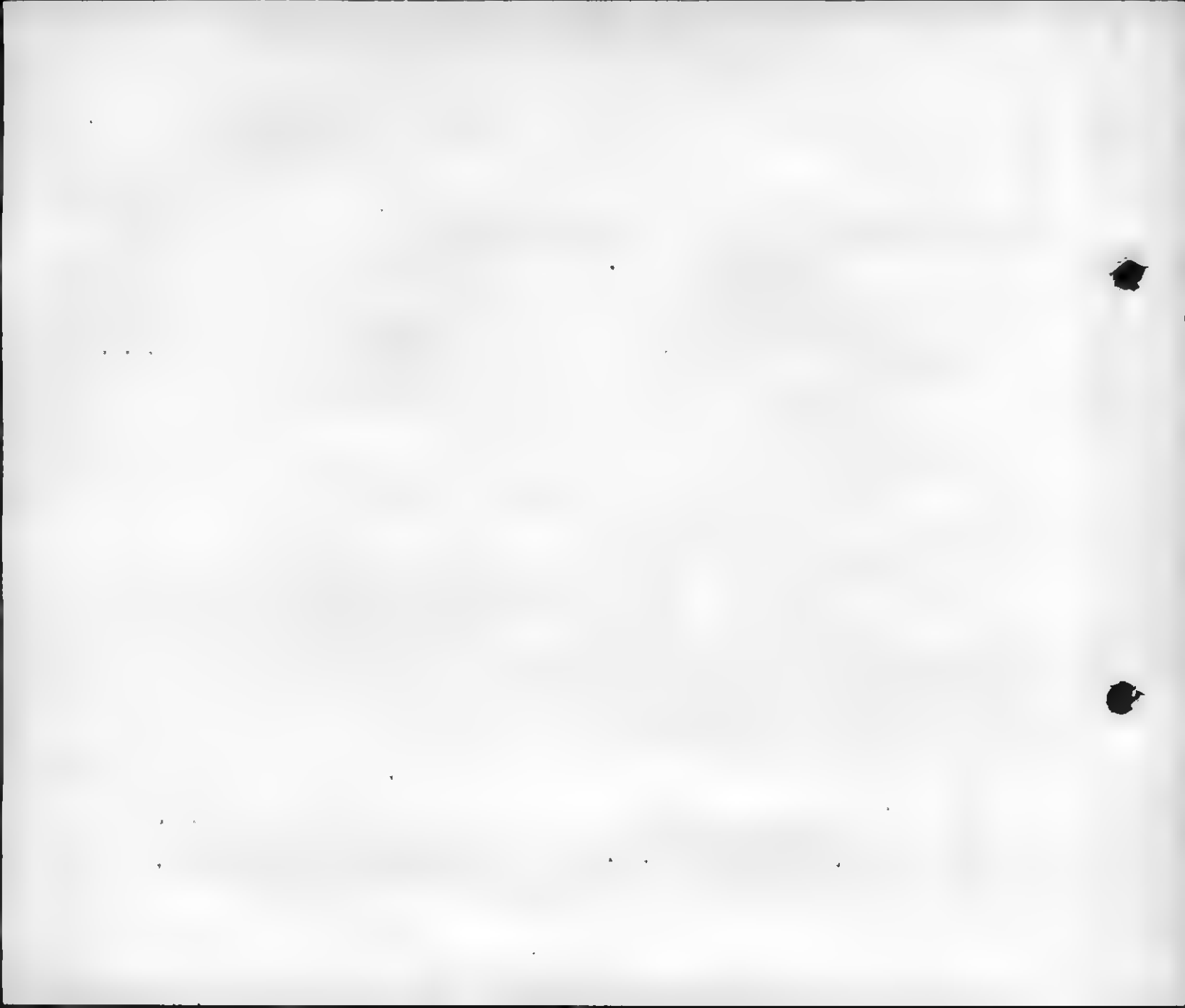
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>7 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>H.</b> Last <b>Henry</b>						4. DATE OF DEATH Month <b>7</b> Day <b>24</b> Year <b>19 58</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>?</b> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1873</b>		9. AGE (In years last birthday) <b>85</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland?</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>522X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>Caroline</b> (State) <b>Caroline</b>			
21. I certify that I attended the deceased from <b>7/17/58</b> , 19 <b>58</b> , to <b>7/24/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/24/58</b> , 19 <b>58</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED															
ACTUAL SIGNATURE <b>L. Benedict</b>				M.D. <b>Crownsville State Hospital, Md.</b>				DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				<b>Crownsville State Hospital, Md.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/28/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union</b>				22d. LOCATION (City, town, or county) (State) <b>Goldsboro Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie</b>						ADDRESS <b>Greensboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur...</b>					



7531 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Ad. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>J.</u> Last <u>Holland</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Holland</u>		14. MOTHER'S MARDEN NAME <u>Elizabeth Brewer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Edith Holland</u>	
17. INFORMANT Address <u>Waterbury Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Central Pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>contusion</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-17-58</u> , 19 <u>58</u> , to <u>7-12-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-12-58</u> , 19 <u>58</u> , and that death occurred at <u>8:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. J. Allen</u> M.D. <u>62 E. Church St</u> PHYSICIAN'S NAME (Type) <u>A. J. ALLEN</u> <u>surgeon, md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-15-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Church</u>	22d. LOCATION (City, town, or county) (State) <u>Waterbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. Annapolis Md</u>		24a. REG. BY REGISTRAR <u>14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7572 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNE ARUNDEL</u>	MARYLAND	STATE <u>PENNSYLVANIA</u>	COUNTY <u>YORK</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>	LENGTH OF STAY (in this place) <u>8 WEEKS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>YORK</u>	OR TOWN <u>YORK</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WENDOVER</u>		STREET ADDRESS (If rural give location) <u>115 WEST 6TH AVE</u>	
3. NAME OF DECEASED: (First) <u>HOWARD</u> (Middle) <u>EDWARD</u> (Last) <u>HOSKINS</u>		4. DATE OF DEATH: (Month) <u>JULY</u> (Day) <u>17</u> (Year) <u>1958</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed May 3, 1955</u>	8. DATE OF BIRTH: <u>1894</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>DAIRY</u>	9. AGE last birthday: <u>74</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>173-03-8414</u>	
17. INFORMANT & ADDRESS: <u>WENDOVER + RIVIERA BEACH, MD</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause (a) <u>260X Diabetes Mellitus</u>		<u>2 years</u>
Antecedent cause(s) (b) <u>DUE TO</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Atherosclerosis, Cardiac Hypertrophy, etc.</u>		20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1955, to July 17, 1958, that I last saw the deceased alive on July 16, 1958, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	(Degree or title)	ADDRESS <u>Riviera Beach, Md.</u>	DATE SIGNED <u>7/17/58</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>July 20, 1958</u>	NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL COM.</u>	LOCATION (City, town, or county) (State) <u>YORK, PA</u>
DATE REC'D BY LOCAL REGISTRAR <u>JUL 19 1958</u>	DEATH CERT. SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>915 N. Duane St York, Pa.</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDER





07548

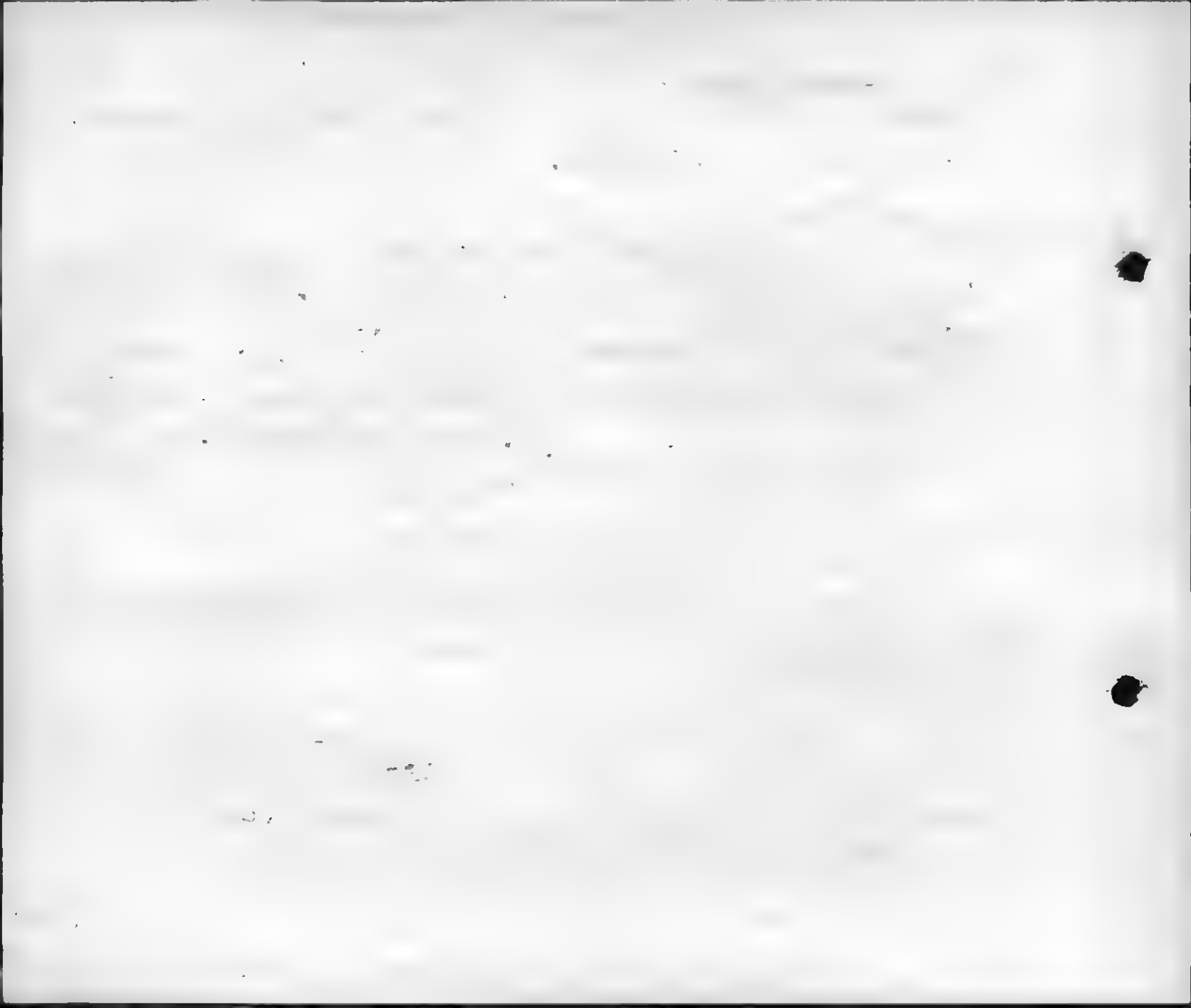
Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>SAME</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRHAVEN</u>		c. LENGTH OF STAY IN 1b <u>2 8 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRHAVEN, Anne Arundel Co., MD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES GARDEN HOWARD</u>		4. DATE OF DEATH Month Day Year <u>JULY 23 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 6, 1986</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>5 17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fireman</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert S. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Ida Amelia Poston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>3</u>	
17. INFORMANT <u>Mrs. Marie Howard, as above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 17, 1958</u> , to <u>JULY 23, 1958</u> , that I last saw the deceased alive on <u>JULY 17/58</u> , and that death occurred at <u>1301 Mass. Ave. NW</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Demas</u>		DATE SIGNED <u>7-23-58</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES JOHN DEMAS</u>		ADDRESS (Street, city or town, state) <u>1301 Mass. Ave. NW - Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, Prince Geo. Co., MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hyson Funeral Home, 1300 N St., N.W., Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 '58</u>	
ADDRESS <u>Hyson Funeral Home, 1300 N St., N.W., Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



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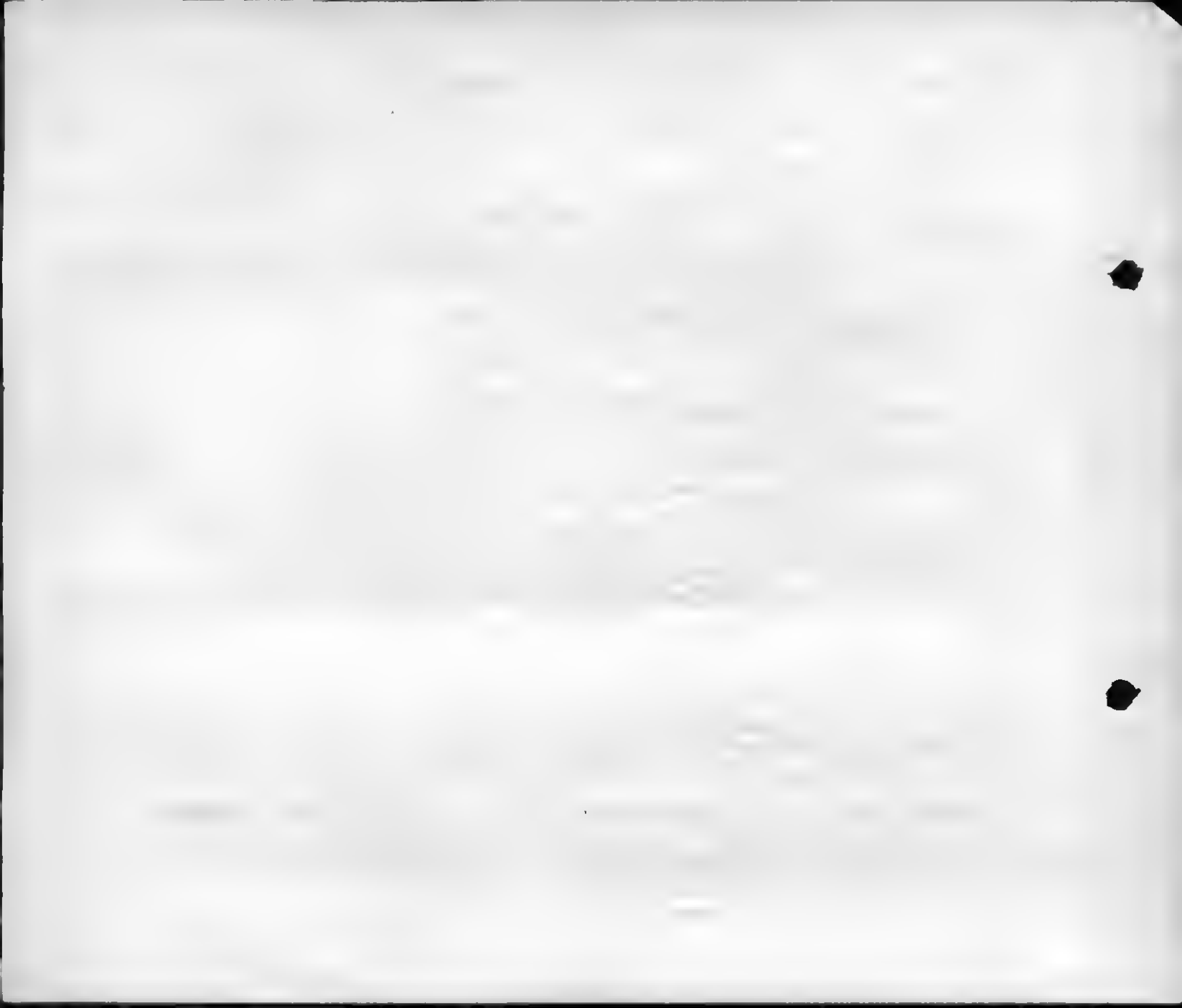
## 7532 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md</u>				c. LENGTH OF STAY IN 1b <u>15 months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, D.C.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN B HUBBE</u>				4. DATE OF DEATH Month Day Year <u>July 6 1958</u>			
5. SEX <u>M</u>				6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>August 6, 1874</u> 82 yrs			
9. AGE (In years last birthday) <u>82</u> yrs				10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INMATE for yrs.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>German Hubbe</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>—</u>			
17. INFORMANT <u>Mr. Geo. Thomas</u> Address <u>1813 N. Montford Ave.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Severe secondary Anemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
DUE TO (b) <u>Probable lower bowel hemorrhage</u>				<u>2 days</u>			
DUE TO (c) <u>(from history of attendant)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1942</u> to <u>July 6 1958</u> , that I last saw the deceased alive on <u>July 6 1958</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D.				ADDRESS (Street, city or town, state) <u>31 Southgate Ave. Annapolis, Md</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>				DATE SIGNED <u>7/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 10, 1958</u>				22b. DATE THEREOF <u>July 10, 1958</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>				22d. LOCATION (City, town, or county) (State) <u>East North West</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leo S. Leach</u> ADDRESS <u>1401 0000 Baltimore Park Ave</u>				24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>			
DATE <u>JUL 14 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

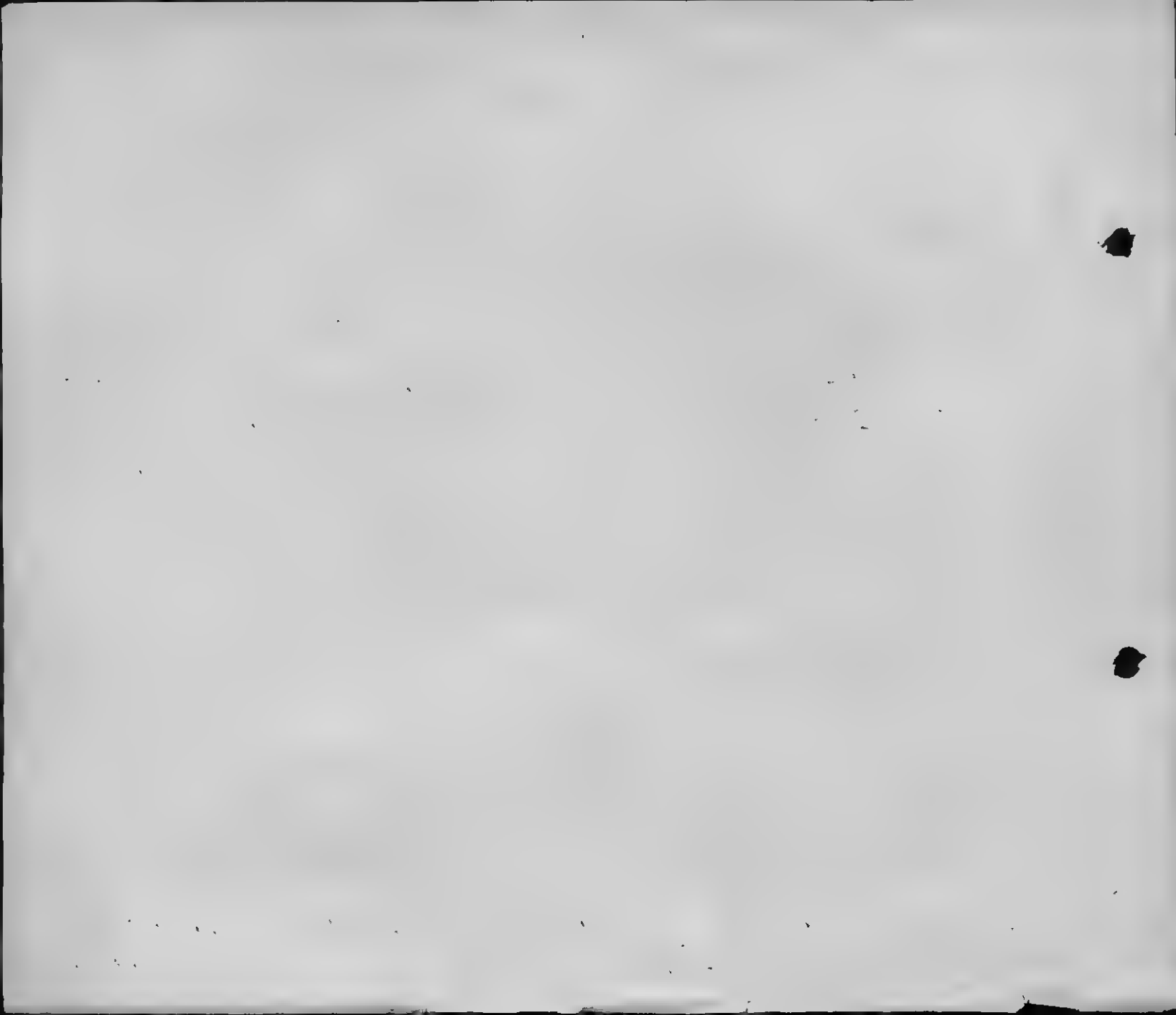


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7574  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

07550 Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MA CO</u>		MARYLAND		STATE <u>New York</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RURAL</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>OZONE PARK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>D.O.A. ANNE ARUNDEL GENERAL</u>				STREET ADDRESS (If rural, give location) <u>107-70-106 ST.</u>			
3. NAME OF DECEASED: (First) <u>MICHAEL</u> (Middle) <u>R.</u> (Last) <u>INNACONE</u>		4. DATE OF DEATH		7		19 58	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>AUG 10, 1925</u>	9. AGE last birthday: <u>32</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>UPHOLSTERER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>FURNITURE</u>		11. BIRTHPLACE (State or foreign country): <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>CAMILLO IANNACONE</u>				14. MOTHER'S MAIDEN NAME: <u>CAROLINE DEFELICE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>UNKNOWN</u>		17. INFORMANT & ADDRESS: <u>LEO F. KEARNS FUNERAL HOME NEW YORK</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>multiple injuries</u> DUE TO							<u>suicide</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>		21c. (City or town) <u>MA CO.</u> (County) <u>MD</u> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7 2 58 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car struck tractor trailer</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. R. L. L.</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>7-2-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>REMOVAL</u>		DATE THEREOF <u>7-3-58</u>		NAME OF CEMETERY OR CREMATORY <u>U.S. NATIONAL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>PINELAWN, NEW YORK</u>	
DATE REC'D BY LOCAL REG. <u>JUL 7 '58</u>		REGISTRAR'S SIGNATURE <u>Wm. Cook</u>		24. FUNERAL DIRECTOR <u>Wm. Cook - Blight, Inc.</u>		ADDRESS <u>6009 Maryland Rd</u>	



## 7533 CERTIFICATE OF DEATH

Reg. Dist. No.

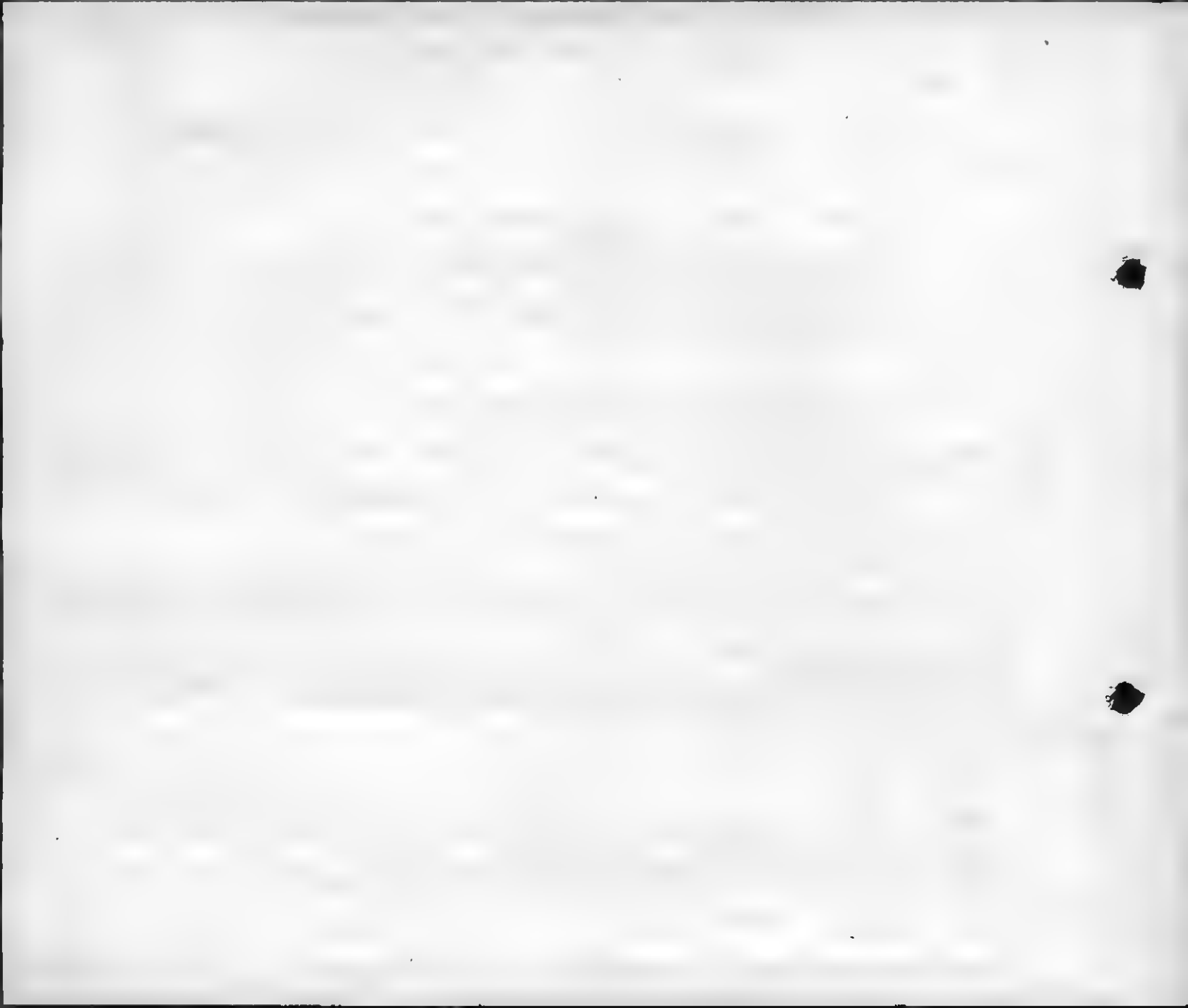
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>				d. STREET ADDRESS <u>1316 FOREST DRIVE</u>			
3. NAME OF DECEASED (Type or print) <u>ALEXANDER</u> First <u>CLIFFORD</u> Middle <u>JOHNSON</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-1915</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>ALEXANDER JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>DOROTHY JOHNSON</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYO CARDIAC INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC CORONARY</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1953</u> , to <u>July 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>58</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>Channopolis Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUL 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7534 CERTIFICATE OF DEATH

07552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Adams County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution—Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Adams County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adamsburg Md</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>512 3rd Street</i>		e. STREET ADDRESS <i>512-3rd Street</i>	
3. NAME OF DECEASED (Type or print) <i>Marvin Lamont Johnson</i>		4. DATE OF DEATH Month <i>7</i> Day <i>28</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-24-1958</i>
9. AGE (In years last birthday) yrs. <i>3</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Bernard Johnson</i>		14. MOTHER'S MARDEN NAME <i>Betty Turner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Betty Turner</i>		Address <i>512-3rd St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO <i>Pneumonia Infected (5 mm p)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>(5 mm p)</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/28</i> , 19 <i>58</i> , to <i>7/28</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7/28</i> , 19 <i>58</i> , and that death occurred at <i>7 A.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i>		ADDRESS (Street, city or town, state) <i>37 Calver Street Annapolis, Md</i>	
PHYSICIAN'S NAME (Type) <i>Dr THEODORE H. JOHNSON</i>		DATE SIGNED <i>Aug 1, 1958</i>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-30-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Kessett</i>		ADDRESS <i>1087 Wash. St. Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>Aug 1 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Kessett</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



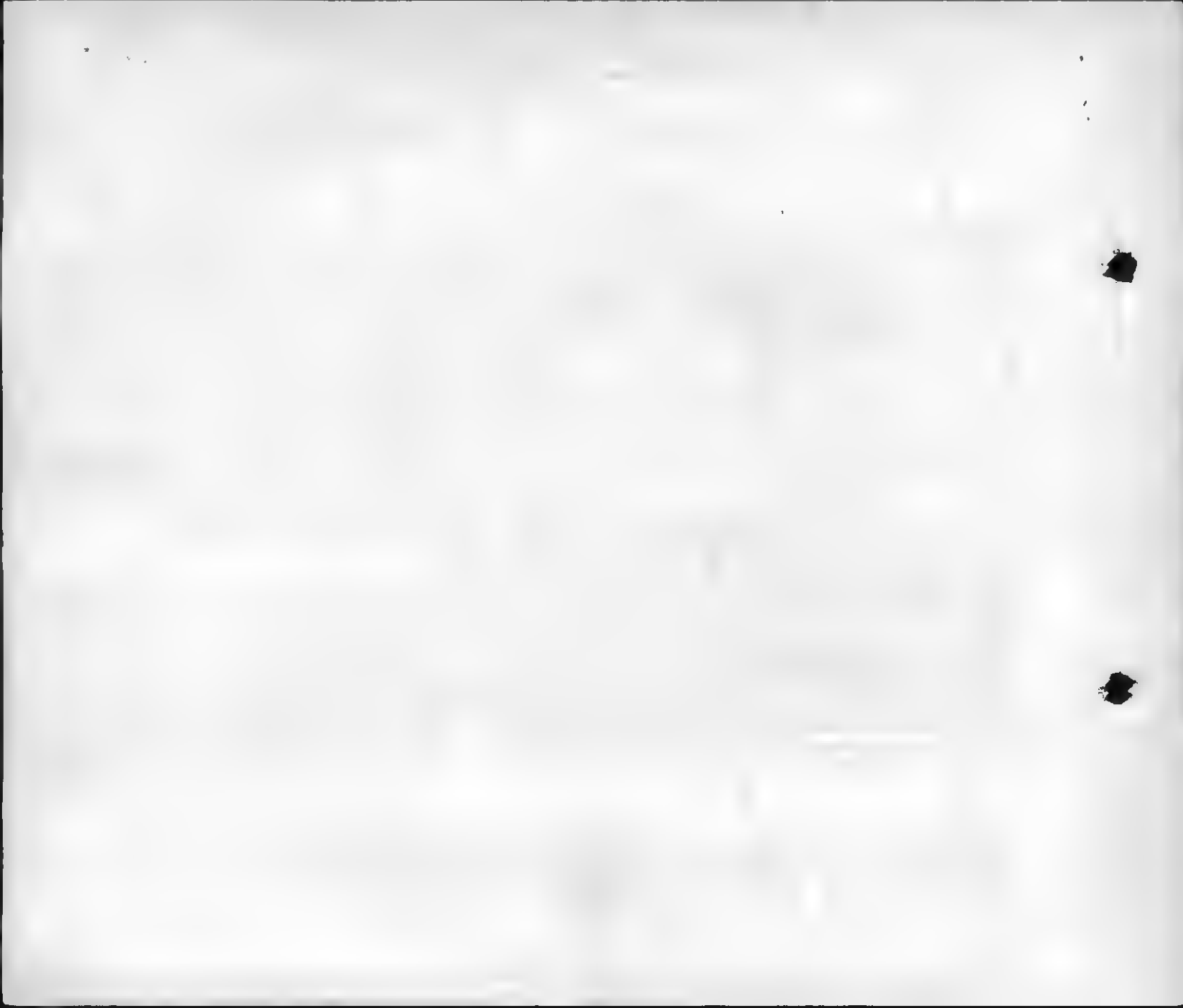
## 7575 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. 4 B 37 Anna. Md.</u>		d. STREET ADDRESS <u>St. 4 B 37 Anna. Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver Johnson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1882</u>
9. AGE (In years, months, and days) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>8</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U.S. Naval Acad.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Henretta Calhoun</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>17</u>	
17. INFORMANT <u>Hermit Johnson</u>		Address <u>St. 4 B 37 Anna. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Hypertensive Cardiac Vascular Disease grade III</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1443x</u> DUE TO (c) <u>144</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/5</u> , 19 <u>57</u> , to <u>7/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/8</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>37 Belmont St. Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-13-1958</u>	<u>Broadneck</u>	<u>Spidmore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Beesett</u>		ADDRESS <u>108 Wash. St. Anna. Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Beesett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7535 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. LENGTH OF STAY IN 1b <u>Rural Waterbury Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>37 Calvert Street</u>		d. STREET ADDRESS <u>Box 52 Waterbury Md.</u>	
3 NAME OF DECEASED (Type or print) <u>Sgt. Nathaniel Jones</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1958</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1910</u>
9. AGE (In years lost birthday) <u>48</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Overhaul Dezerick Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jones</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-092994</u>	
17. INFORMANT <u>Elise Marie Jones</u>		Address <u>Box 52 Waterbury Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>241X</u> DUE TO <u>Complicated by Long Binded Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>56</u> , to <u>7/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>58</u> , and that death occurred at <u>  </u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Therese H. Johnson MD</u>		ADDRESS (Street, city or town, state) <u>31 Calvert Street</u>	
PHYSICIAN'S NAME (Type) <u>Dr. THEODORE H. JOHNSON</u>		DATE SIGNED <u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carroll Memorial Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mitchellville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese</u>		ADDRESS <u>108 Wash. St. Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JUL 17 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



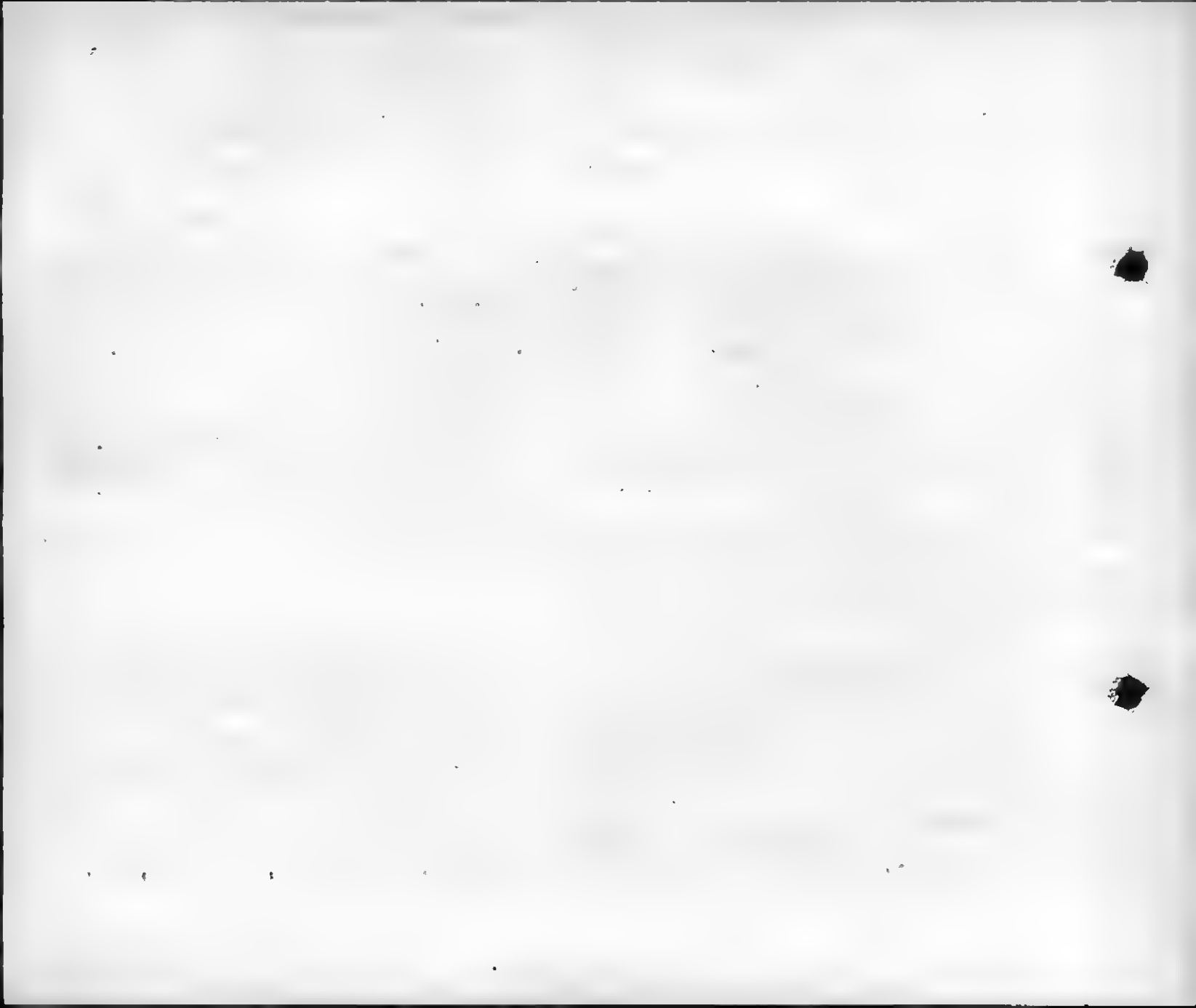
07555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>		c. LENGTH OF STAY IN 1b <b>38 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridge Road</b>				d. STREET ADDRESS <b>Ridge Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY</b>		First <b>KAWECKI</b>		Last		4. DATE OF DEATH <b>July 27, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1899</b>		9. AGE (In years last birthday) <b>59</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Duck-Worth Hatch.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Kaweck</b>				14. MOTHER'S MAIDEN NAME <b>Theresa Dragon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 218-14-6889</b>		17. INFORMANT <b>Mrs. Martha Utz, Hanover, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident (left)</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>sev. yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1958</b> , to <b>July 27, 1958</b> , that I last saw the deceased alive on <b>June 30, 1958</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>E. Roderick Shipley M.D. July 28/58</b>							
ACTUAL SIGNATURE <b>E. Roderick Shipley</b>							
PHYSICIAN'S NAME (Type) <b>E. Roderick Shipley, 721 Med. Arts Bldg., Balto., Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 30/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary Dundalk, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Snygdon</b>				ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 31 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>							

VS A15 (4)  
15M 10/57





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7577 CERTIFICATE OF DEATH

07556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b> c. LENGTH OF STAY IN 1b <b>65 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Camp Meade Road</b>			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Severn</b> d. STREET ADDRESS <b>1 Camp Meade Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>ETHEL ADELIA KELLY</b>			4. DATE OF DEATH Month Day Year <b>July 7, 1958</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Sept. 5, 1890</b>		9. AGE (In years last birthday) yrs <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 yrs.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		13. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. FATHER'S NAME <b>John Stewart</b>		16. MOTHER'S MAIDEN NAME <b>Racheal Clark</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>none</b>		19. INFORMANT <b>Mr. Lewis Kelly</b> Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Cardio Vascular Disease</b> DUE TO (b) DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>1948</b> , 19 <b>July 7</b> , 19 <b>58</b> that I last saw the deceased alive on <b>July 3</b> , 19 <b>58</b> and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>108 Central Ave., Glen Burnie, Md.</b> DATE SIGNED <b>7/8/58</b>					
ACTUAL SIGNATURE <b>James S. Billingslea</b> M.D.					
PHYSICIAN'S NAME (Type) <b>James S. Billingslea</b> #108 Central Ave., Glen Burnie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county)		(State)		<b>Brooklyn, RFD, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Sington</b>		ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Sington</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07557

Item 9 Film #231 7-25-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> c. LENGTH OF STAY IN 1b <u>7 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5524 Patrick Henry Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>40</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>Same</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mrs. Nellie King</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>July 19th.</u> 19 <u>58</u> Month Day Year							
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/12/84</u>		<b>9. AGE</b> (In years last birthday) <u>73 3/4</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Southampton, England.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>British</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Irene Anderson (niece)</u> Address <u>same address.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>40 1.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b>		
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>7/19/58</u>					
<b>22a. BURIAL, CREMATION, or other disposition</b> <u>Buried</u>				<b>22b. DATE THEREOF</b> <u>7-22-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>London Park Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McCully Funeral Home</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 22 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7579

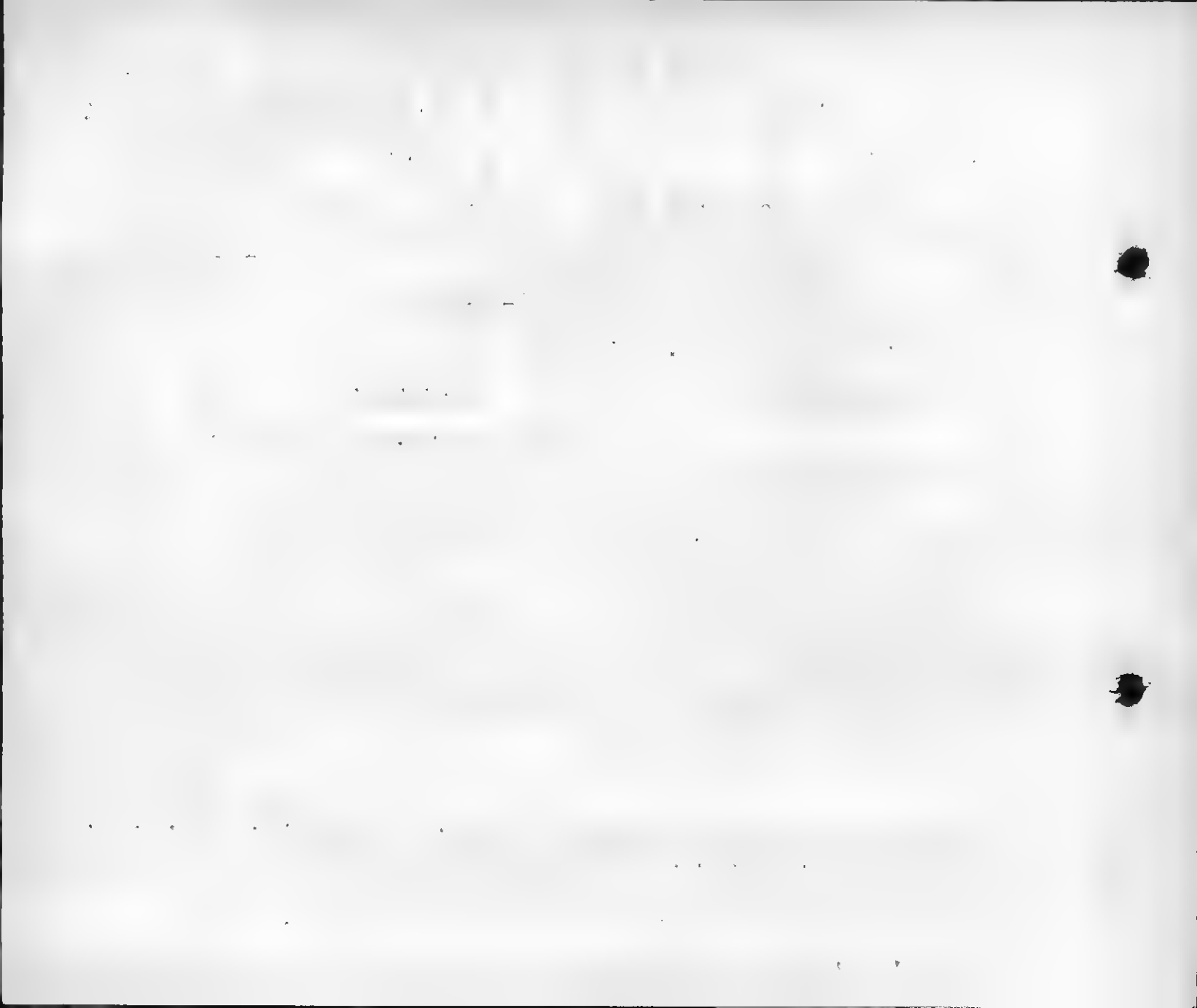
CERTIFICATE OF DEATH

Reg. Dist. No.

07558

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>Marley Neck Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Lee</b> Last		4. DATE OF DEATH Month <b>7-28-58</b> Day <b>19</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-1880</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>58</b> Min.	IF UNDER 24 HRS Months <b>7</b> Days <b>28</b> Hours <b>58</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Hannibal Hampton Lee</b>	
14. MOTHER'S MAIDEN NAME <b>Virginia Ridgely</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>(11 yes, give war or dates of service)</b>		17. INFORMANT <b>Plaza Manor Nursing Home Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Scoliosis Dorsal Spine, Osteoarthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>58</b> , to <b>July 28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 27</b> , 19 <b>58</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James M. Pair</b>		ADDRESS (Street, city or town, state) <b>400 N. Carrollton Ave. Balto. 23, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		DATE SIGNED	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>31 July 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. AUBURN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law, 802 Madison Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 30 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use with the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

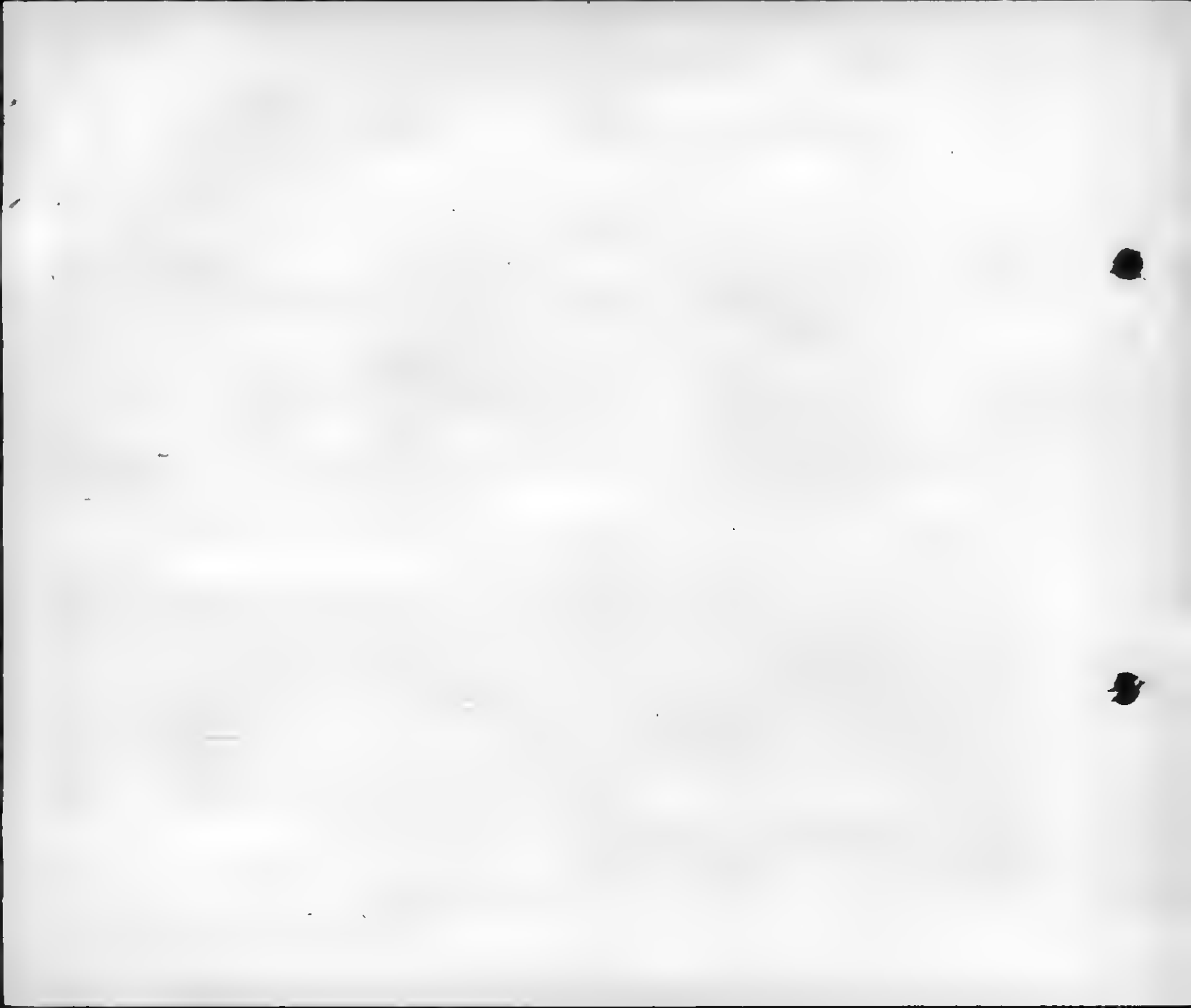
Reg. Dist. No.

07559

7580

1. PLACE OF DEATH a. COUNTY <i>AA.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>P.H.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>708 S. Camp Meade Rd.</i>		c. LENGTH OF STAY IN 1b <i>35 yr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Linthicum</i>		d. STREET ADDRESS <i>108 S. CAMP MEADE RD.</i>	
3. NAME OF DECEASED (Type or print) <i>Martha Tomlinson Litchfield</i>		4. DATE OF DEATH <i>July 4 1958</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 30 1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>Robert B Tomlinson</i>		14. MOTHER'S MAIDEN NAME <i>Martha Read</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hazel Cromwell</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO <i>Arterio Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2-3 yr.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1958</i> to <i>July 4 1958</i> , that I last saw the deceased alive on <i>July 4 1958</i> , and that death occurred at <i>11:42 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i>		ADDRESS (Street, city or town, state) <i>M.D. Linthicum</i>	
PHYSICIAN'S NAME (Type) <i>Chas. L. Ball, Jr.</i>		DATE SIGNED <i>7/4/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>July 8, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ZION</i>	22d. LOCATION (City, town, or county) (State) <i>DORSEY, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John O. Mitchell &amp; Son Inc. 1900 Entaw Place</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 8 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Al. Smith</i>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Annapolis Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Archibald Lourie</u> First Middle Last 4. DATE OF DEATH <u>July 10 1958</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/27/09</u> 9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman of hydraulic equipments.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>West New York, New Jersey.</u> 11. BIRTHPLACE (State or foreign country) <u>USA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Lawrence Lourie</u> 14. MOTHER'S MAIDEN NAME <u>Christina Urquhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO 17. INFORMANT <u>Mrs. Susan Lourie (wife)</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self inflicted wound to the head</u> <u>9/16 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Due to</u> (c) <u>Due to</u> cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself through the mouth with a 12 gauge rifle.</u> 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10:42</u> p. m. <u>7/10/58</u> 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <u>In the orchard</u> 20f. (City or town) <u>Arnold</u> (County) <u>AA.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/10/58 22a. BURIAL, CREMATION, 22b. DATE THEREOF <u>7-11-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u> 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Ann Arbor, Mich</u> 24a. REC'D BY REGISTRAR <u>John M. Taylor</u> 24b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u> DATE <u>JUL 14 '58</u>			



7582

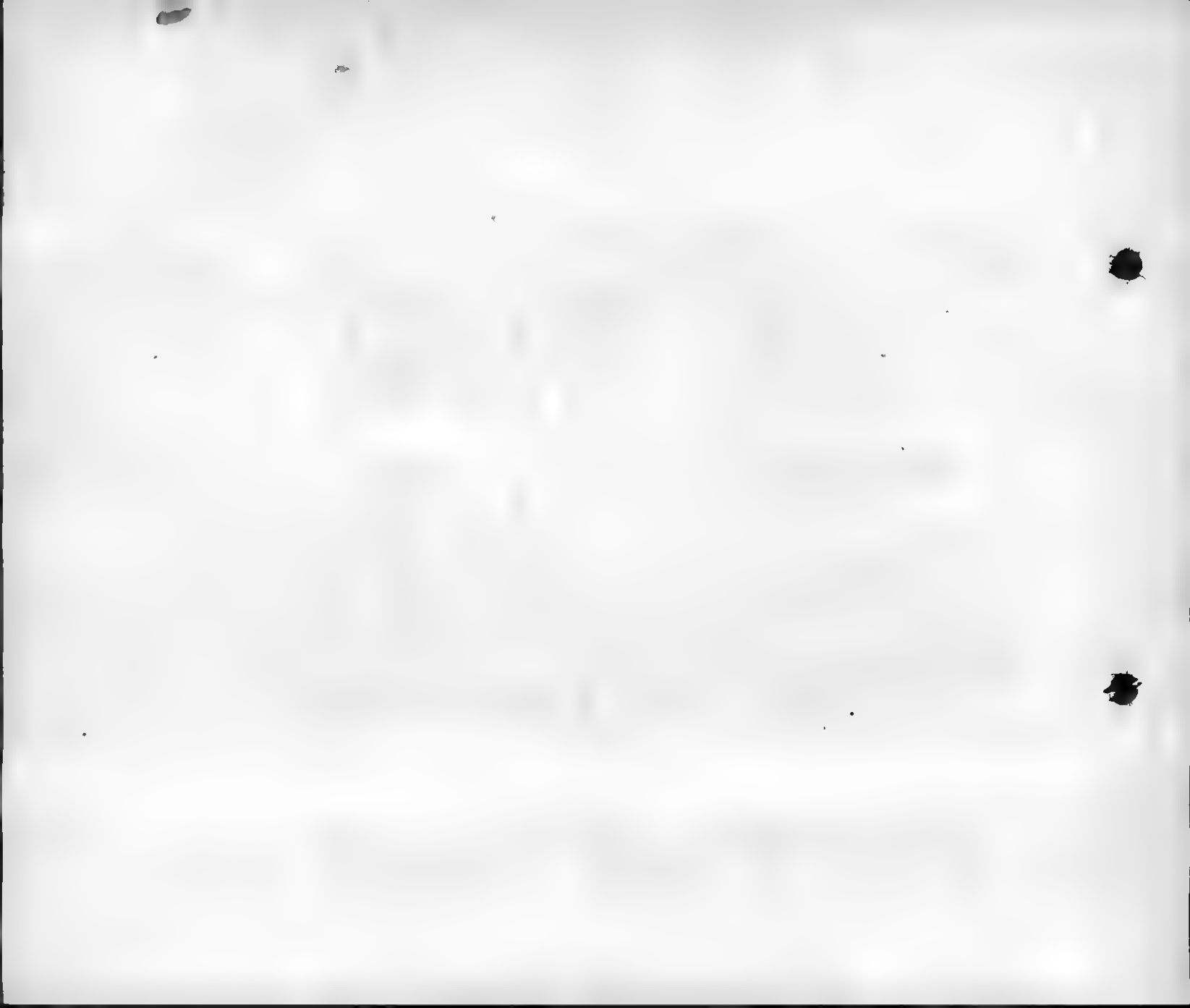
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Creek, Off Green Haven County Peer, 1819 Belt Street,</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Coral Eldred Magers</u>				4. DATE OF DEATH <u>July 17th.</u> 1958			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/8/21</u>	
9. AGE (In years last birthday) <u>36</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>K &amp; L Air Cond.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Charles E. Magers</u>				14. MOTHER'S MAIDEN NAME <u>Edna May Porter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes, World War # 11</u>				16. SOCIAL SECURITY NO. <u>212-16-6395</u>		17. INFORMANT <u>Clarence E. Magers, 2307 Lincoln Ave., Baltimore.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Dove off the Peer in 12 feet of water and could not swim.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:45</u> p. m. <u>7/17/58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stoney Creek, Green Haven, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/17/58			
22a. BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>		22b. DATE THEREOF <u>7-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Faubert</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7583 CERTIFICATE OF DEATH

07562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>7 m 4 d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Rt. 2 Box 6</b>			
3. NAME OF DECEASED (Type or print) First <b>Ervil</b> Middle <b>Matthews</b> Last <b>Matthews</b>				4. DATE OF DEATH Month <b>7</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 2, 1906</b>		9. AGE (In years lost birthday) <b>52</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Clarence Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>(Hemangioblastoma of Cerebellum left side)</b> DUE TO <b>1. Brain Tumor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>14 7:14</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>12/2</b> , 19 <b>57</b> , to <b>7/6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/6/58</b> , 19 _____, and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED _____ SIGNATURE <b>Hildegard Reissmann</b> PHYSICIAN'S NAME (Type) <b>Hildegard Reissmann, M. D.</b> <b>Crownsville State Hospital, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-12-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moses</b>		22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rollins, Myrtle K.</b> ADDRESS <b>4339 Hunt Pl. E</b>				24a. REC'D BY REGISTRAR <b>7-1-58</b> DATE <b>JUL 9 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>	



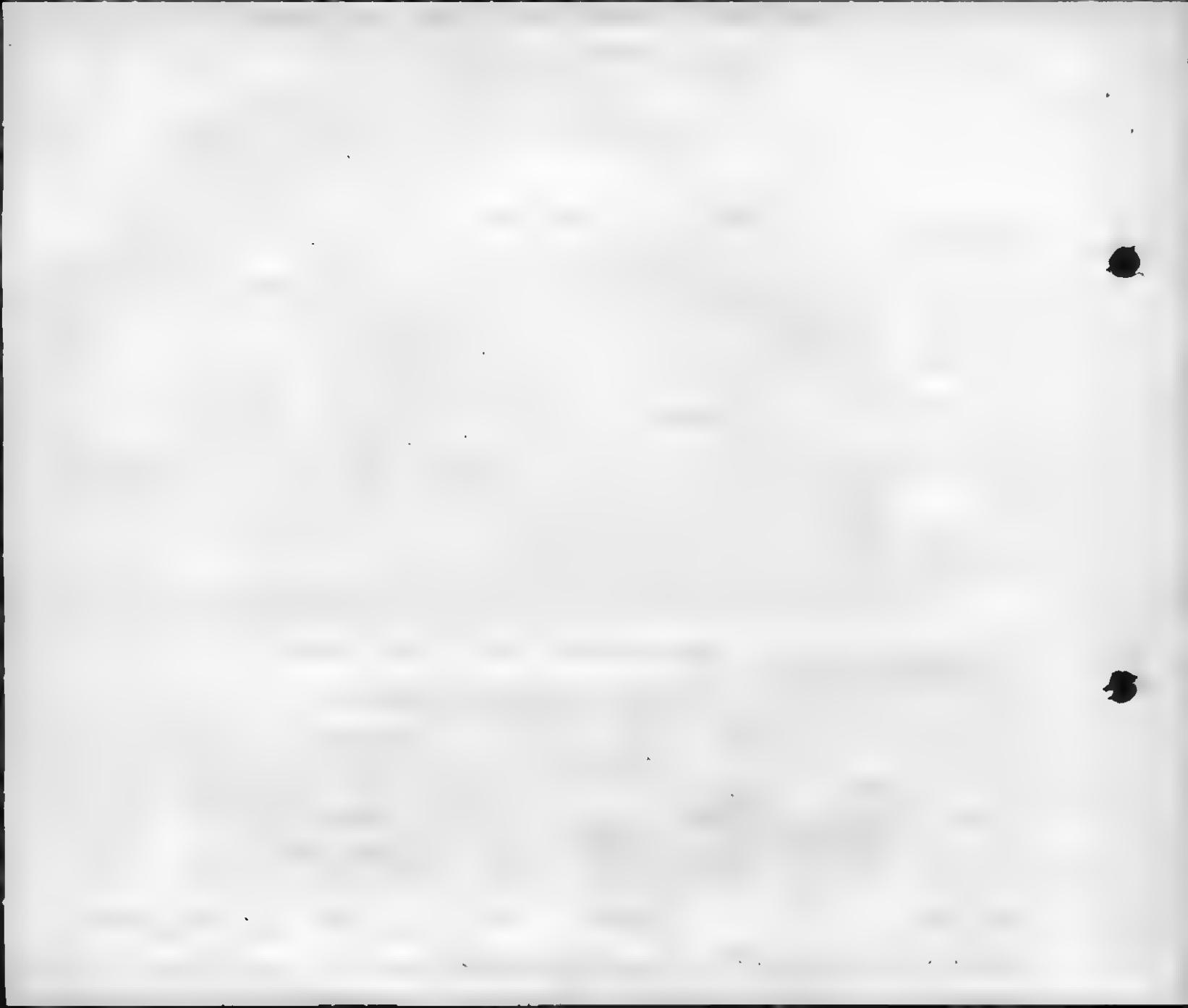
CERTIFICATE OF DEATH

Reg. Dist. No.

7584

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Annapolis, MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rd 5 Box 405</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LUCRETIA</u> First Middle Last <u>MATTHEWS</u>		4. DATE OF DEATH <u>7-1-58</u> Month Day Year <u>19</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-92</u> 9. AGE (In years lost birthday) yrs. <u>65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Sally Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John H. Matthews</u>	
14. MOTHER'S MAIDEN NAME <u>Lucretia Edwards</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Son - Rd 5 Box 405</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>90 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-11-58</u> , 19 <u>58</u> to <u>7-1-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-27-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>7-2-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		<u>CL CATHEDRAL ST</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Walls Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>		24a. REC'D BY REGISTRAR <u>7 58</u>	
ADDRESS <u>Montgomery Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	





7585

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

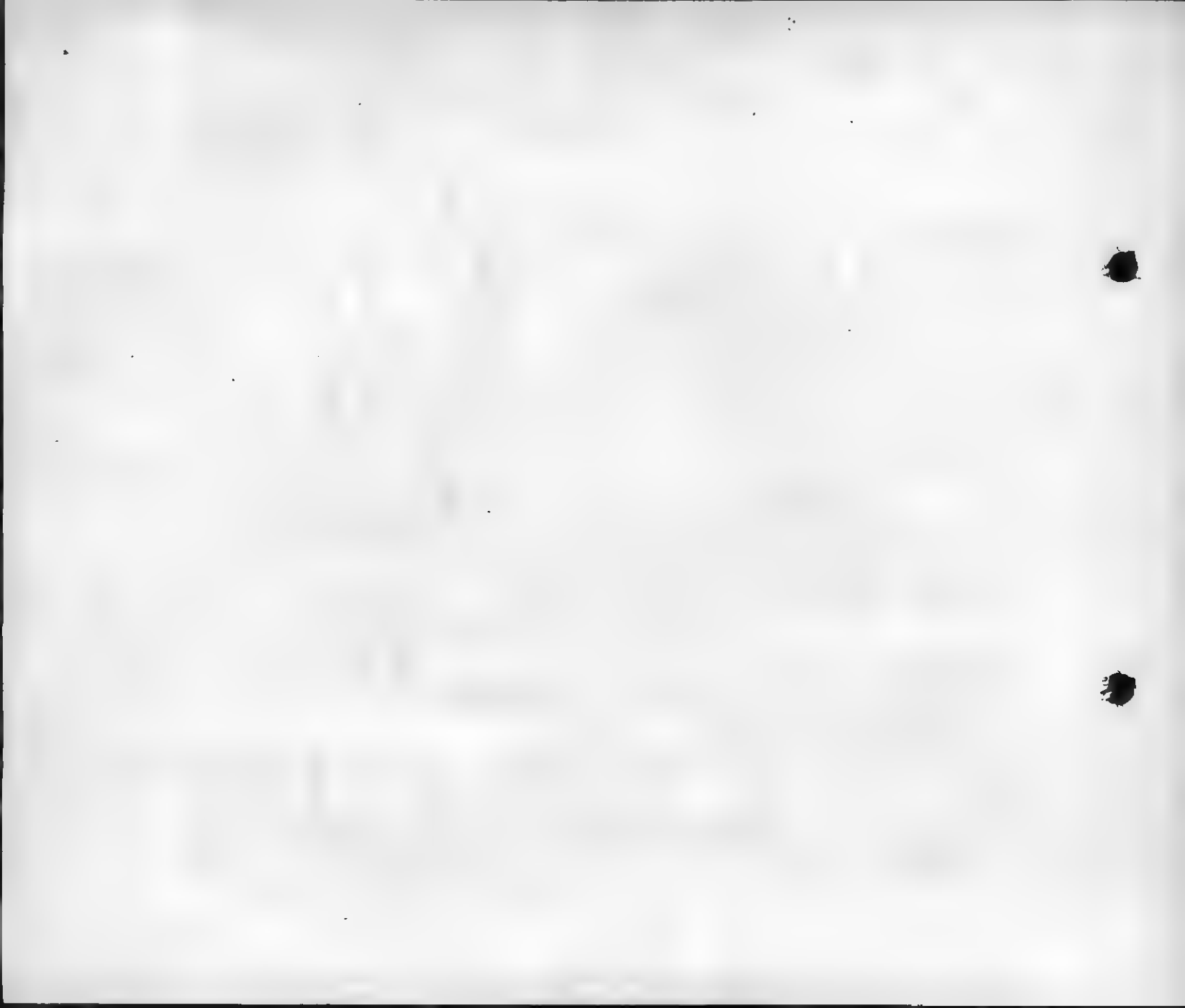
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>70 Rhode Island Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>William F Matthews</u>		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1933</u>
9. AGE (In years last birthday) <u>24</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>	
11. IF UNDER 24 HRS. Hours <u>4</u> M n.		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>212-30-7214</u>	
17. INFORMANT <u>Dr. Beck - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8160X</u> DUE TO <u>SKULL</u> Conditions, if any, which gave rise to immediate cause (b) <u>Automobile accident</u> (c) <u>stating the underlying cause lost</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:15</u> p.m. <u>7-20-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Bristol</u> (County) <u>Anne Arundel</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward L. Beck</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. DATE OF CREMATION OR REMOVAL (Specify) <u>7-23-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>		22d. LOCATION (City, town, or county) <u>Shadeside</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>W. Reese</u> 24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>	
DATE <u>JUL 23 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



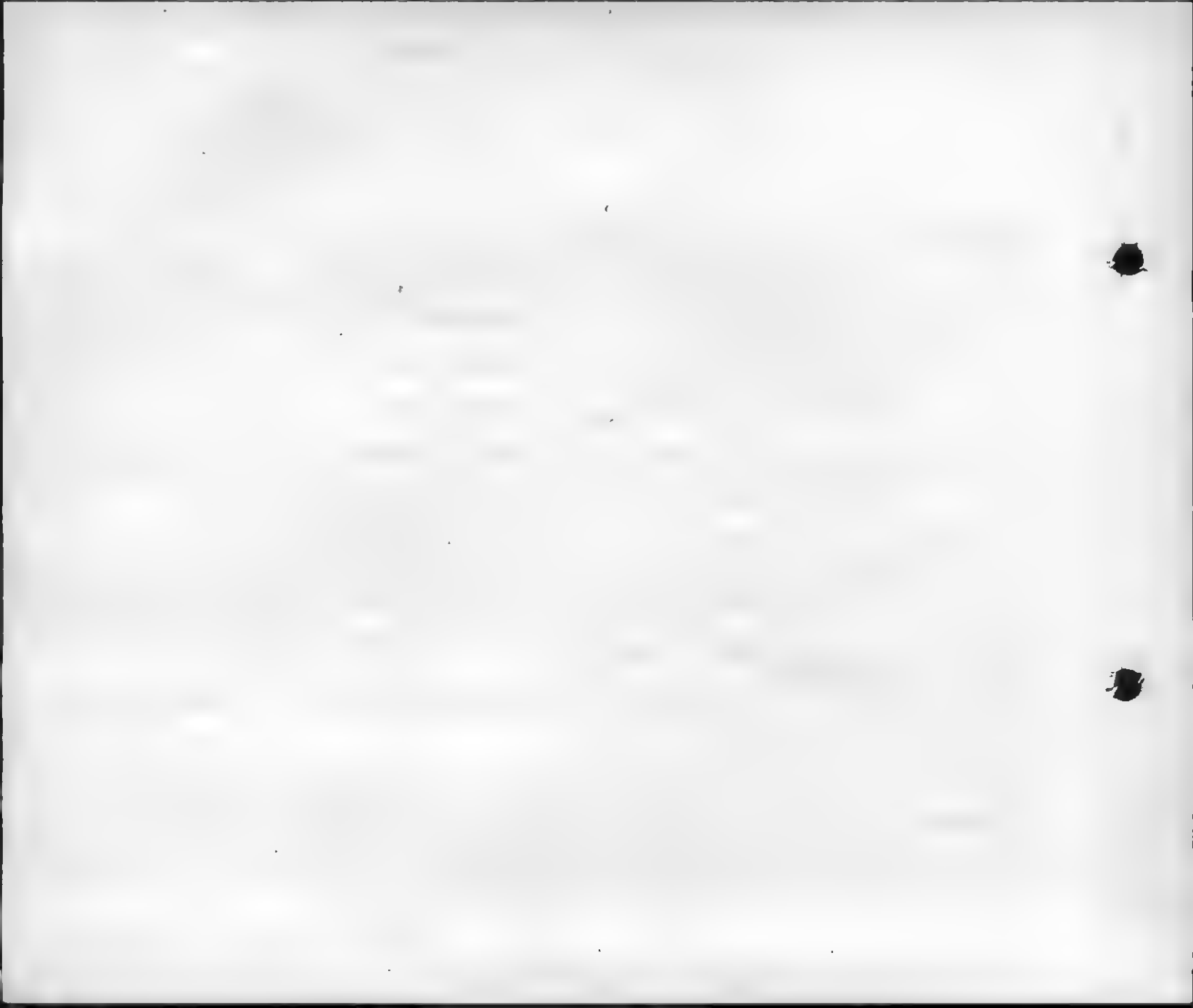
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **07565**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <b>MD</b> b. COUNTY <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cape St. Clair</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Minneapolis</b>		d. STREET ADDRESS <b>Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Virginia Dare McPherson</b>		4. DATE OF DEATH <b>7-3-58</b> 19 <b>58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1875</b>
9. AGE (in years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
11. BIRTH PLACE (State or foreign country) <b>Gloucester Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John R. White</b>		14. MOTHER'S MAIDEN NAME <b>Julia Degg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Daughter</b>	
17. INFORMANT <b>Daughter</b>		Address <b>Daughter</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b>			
DUE TO <b>Generalized Arteriosclerosis</b>			
DUE TO <b>Generalized Arthritis</b>			
DUE TO <b>Optic Atrophy</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Optic Atrophy</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>58</b>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1, 1958</b> to <b>July 3, 1958</b> , that I last saw the deceased alive on <b>July 1, 1958</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Severna Park Md 7-3-58</b>			
DATE SIGNED <b>July 3, 1958</b>			
ACTUAL SIGNATURE <b>Robert B. Halpin</b>			
PHYSICIAN'S NAME (Type) <b>Robert B. HALPIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>July 5, 1958</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Rocky, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Miller</b>			
ADDRESS <b>254 Carroll St NW DC</b>			
24. REC'D BY REGISTRAR <b>JUL 7 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>W. S. Beach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



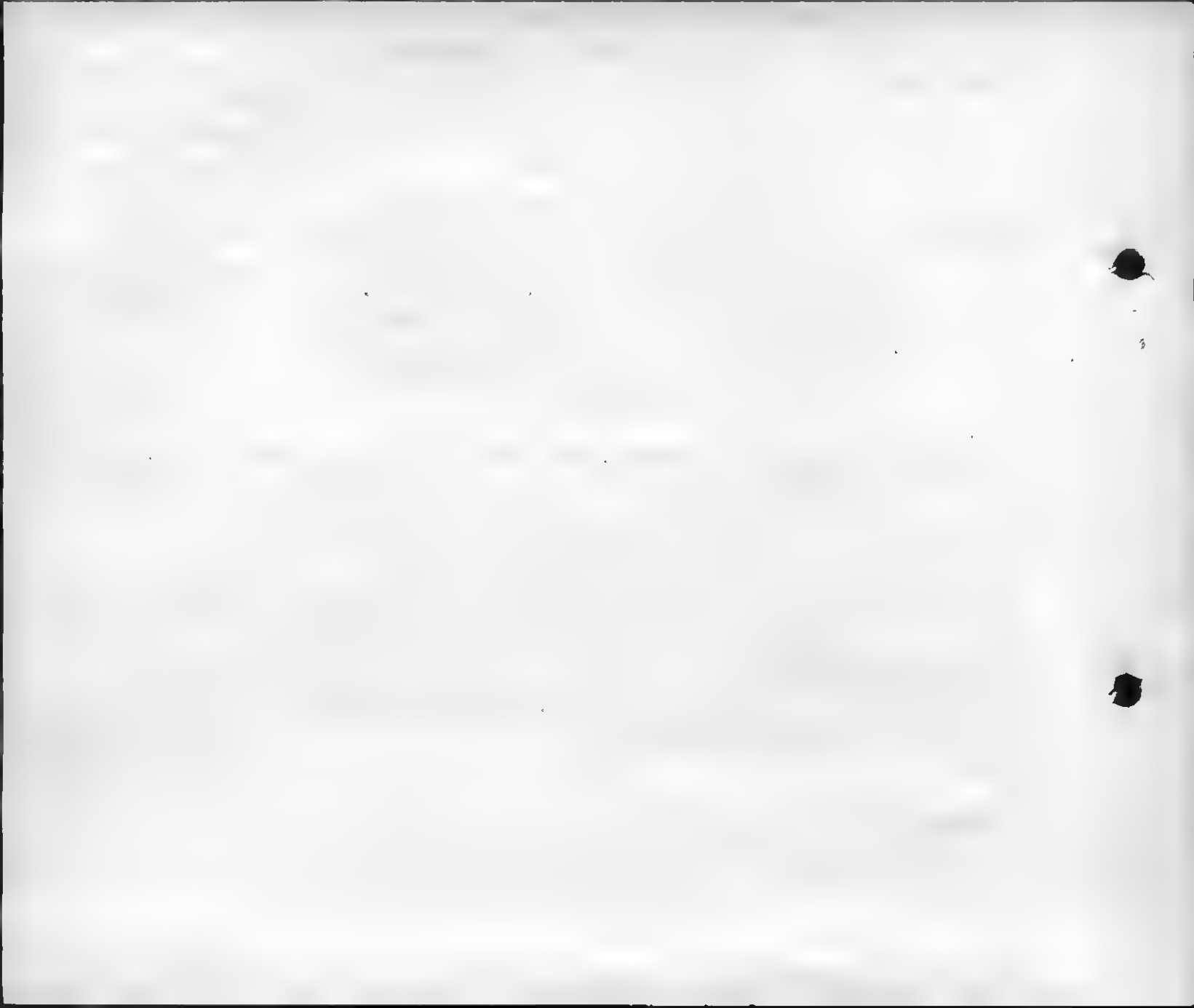
## 7587 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>D.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>101 10<sup>th</sup> Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Mary J. Moore</i>		4. DATE OF DEATH <i>7-27-58</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-20-83</i>
9. AGE (In years last birthday) <i>74</i>		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MD</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Wm. B. King</i>	
14. MOTHER'S MAIDEN NAME <i>Mary A. Stimpert</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i> Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack</i>			
422.1 DUE TO <i>Heart attack</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>None</i>			
DUE TO (c) <i>None</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/20/58</i> to <i>7/27/58</i> , that I last saw the deceased alive on <i>7/27/58</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Wm. B. King</i> M.D.		DATE SIGNED <i>7/27/58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7-25-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	22d. LOCATION (City, town, or county) (State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. B. King</i> ADDRESS <i>Home</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. B. King</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07567

Reg. Dist. No.

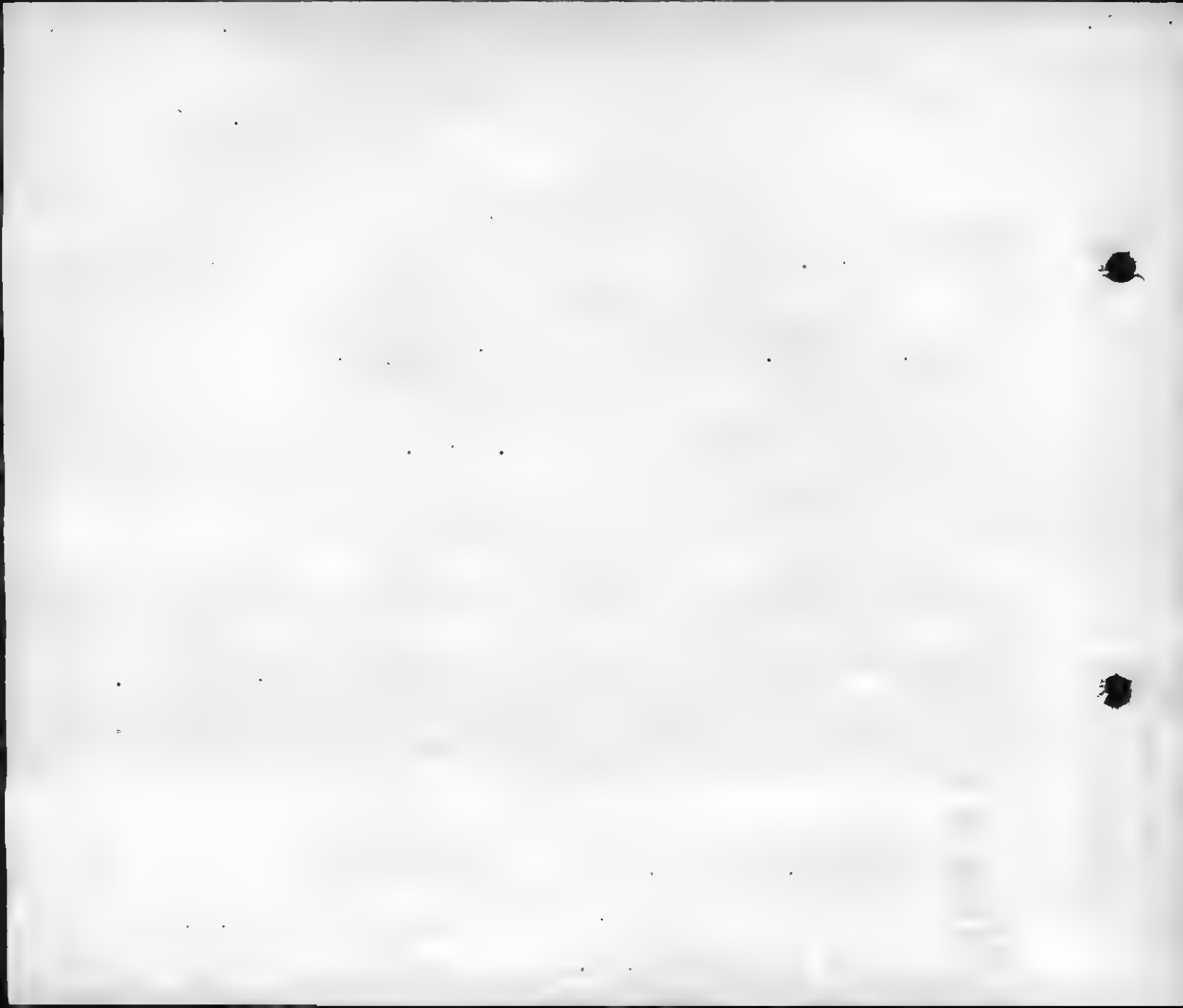
7588

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If out of corporate limits, write RURAL, and give nearest town) <u>Arnold</u>		c. LENGTH OF STAY IN 1b <u>7 hours</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lake Placid (contributory of Magothy River, Box 530 Route 2</u>			d. STREET ADDRESS <u>Box 530 Route 2</u>		
3. NAME OF DECEASED (Type or print) <u>Jesse J. Morgan</u>			4. DATE OF DEATH Month <u>July</u> Day <u>4th</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/08</u>	9. AGE (In years last birthday) <u>49</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> M'n. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Body and fender man.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Charlotte, N.C.</u>	
13. FATHER'S NAME <u>Drew Morgan</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-0274</u>		17. INFORMANT <u>Mrs. Mary E. Morgan (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>914.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Was drilling a hole in his boat with an electric drill.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>a.m.</u> <u>7/4/58</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lake Placid</u>	20f. (City or town) <u>Arnold</u>	(County) <u>A.A.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/4/58</u>			
NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>July 6, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Antioch Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Union County, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	





7589

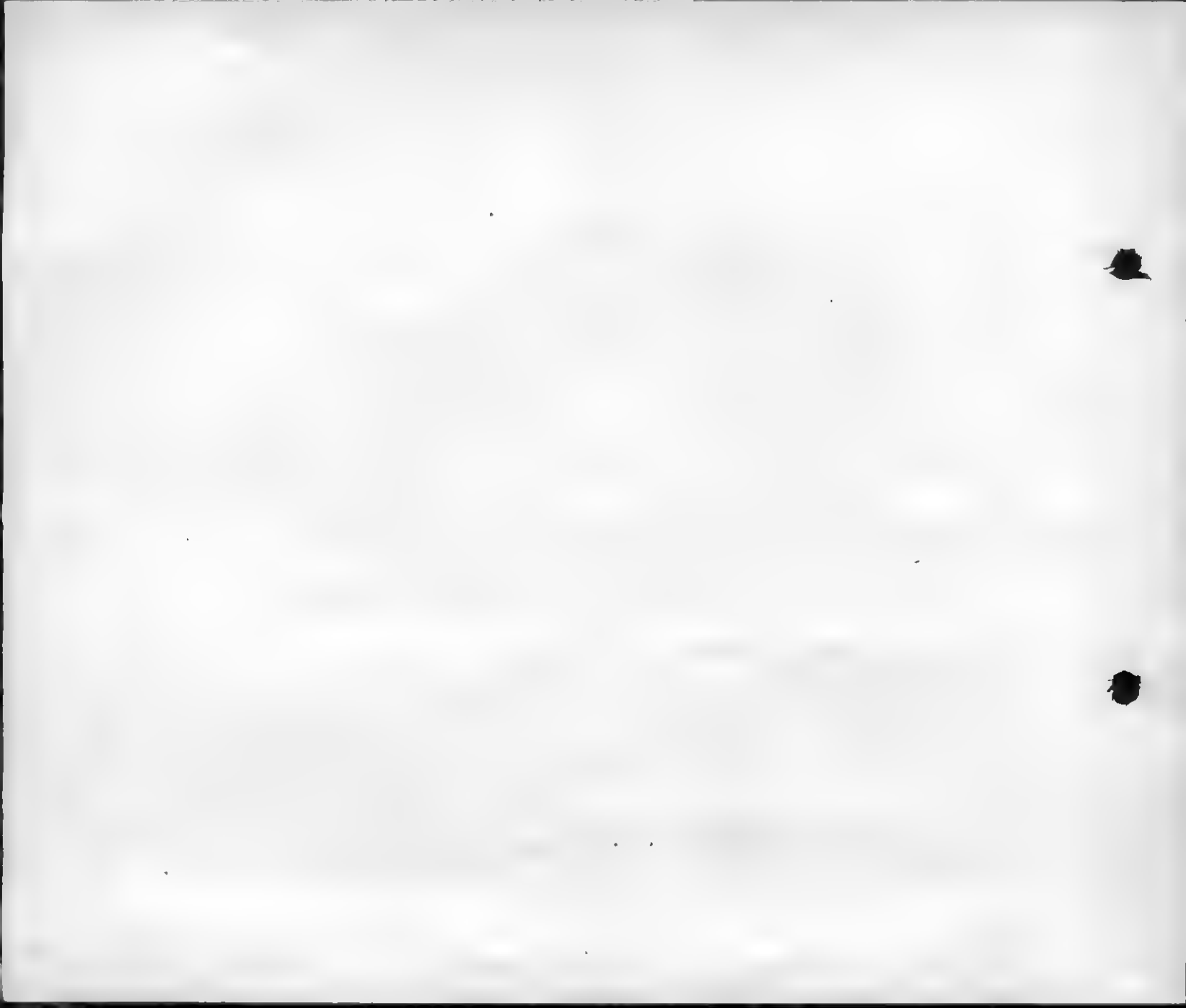
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07568

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Crownville</u> , <u>AA</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownville State Hosp</u>		d. STREET ADDRESS <u>Rt. 1 Box 21</u>	
3. NAME OF DECEASED (Type or print) <u>James Ozzie Newton</u>		4. DATE OF DEATH <u>July 11 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>So. Ca.</u>	
11. BIRTH PLACE (State or foreign country) <u>So. Ca.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Newton</u>		14. MOTHER'S MAIDEN NAME <u>Lula unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-11-7023</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock - circulatory failure</u> + <u>100%</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Innumera, organum unknown, ca 36 hrs.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-10-58</u> to <u>7-11-58</u> , that I last saw the deceased alive on <u>7-11-58</u> , and that death occurred at <u>12:50</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>K. Weber</u>		DATE SIGNED <u>7/11/58</u>	
PHYSICIAN'S NAME (Type) <u>KONSTANTIN WEBER</u>		ADDRESS (Street, city or town, state) <u>Crownville State Hospital, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 17, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton A. Stewart</u>		24. REC'D BY REGISTRAR <u>Clinton A. Stewart</u>	
ADDRESS <u>Salisbury Md.</u>		DATE <u>JUL 21 '58</u>	



# 1 7590 Item 11 Film 7/22/58 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07569

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>G &amp; C</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <u>G &amp; C</u> COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>205 Linda Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wallis</u> Middle <u>G</u> Last <u>Newton</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1866</u>
9. AGE (In years last birthday) <u>92</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cat Highway</u>	
11. BIRTHPLACE (State or foreign country) <u>Little Valley, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Myron Newton</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Newton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Pauline Newton</u>		Address <u>205 Linda Ave G &amp; C</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>400.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 30</u> , 19 <u>57</u> , to <u>June 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florian P Nadolski</u>		DATE SIGNED <u>7-1-58</u>	
PHYSICIAN'S NAME (Type) <u>Florian P Nadolski</u>		ADDRESS (Street, city or town, state) <u>2703 Hammond, Long Rd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Little Valley Rural Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Little Valley, Catt. Co. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson</u>		ADDRESS <u>2337 Wash Blvd</u>	
24a. REC'D BY REGISTRAR <u>JUL 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Pauline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2/57

Item 20 Fill in MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07570

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 51	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GEN</u>		d. STREET ADDRESS <u>2736 LAURETTA AVE</u>	
3. NAME OF DECEASED (Type or print) <u>DANIEL</u> First <u>H</u> Middle <u>Norris</u> Last	4. DATE OF DEATH <u>7-19-1958</u> Month <u>7</u> Day <u>19</u> Year <u>1958</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/02</u> 56 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER MANUFACT.</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>
13. FATHER'S NAME <u>DANIEL NORRIS</u>		14. MOTHER'S MAIDEN NAME <u>SUE TUPPIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>215-01-2961</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		17. INFORMANT <u>Gladys Norris 2736 Lauretta Ave</u> Address	
PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Boat capsized</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year <u>7/19/58</u> 19 Hour <u>1:10</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>water Chesapeake Bay</u>		20f. (City or town) <u>Anne Arundel</u> (County) (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Smith</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-20-58</u>	
EXAMINER'S NAME (Type) <u>William V. Smith</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. REC'D BY REGISTRAR <u>W. Smith</u>	
22a. BURIAL CREMATION or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt CALVARY</u>		22d. LOCATION (City, town, or county) <u>Brooklyn A.A.C.O MD</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hayes 638 N. GLENN ST</u>		24a. REGISTRAR'S SIGNATURE <u>W. Smith</u>	
DATE <u>JUL 21 '58</u>			



## 7591 CERTIFICATE OF DEATH

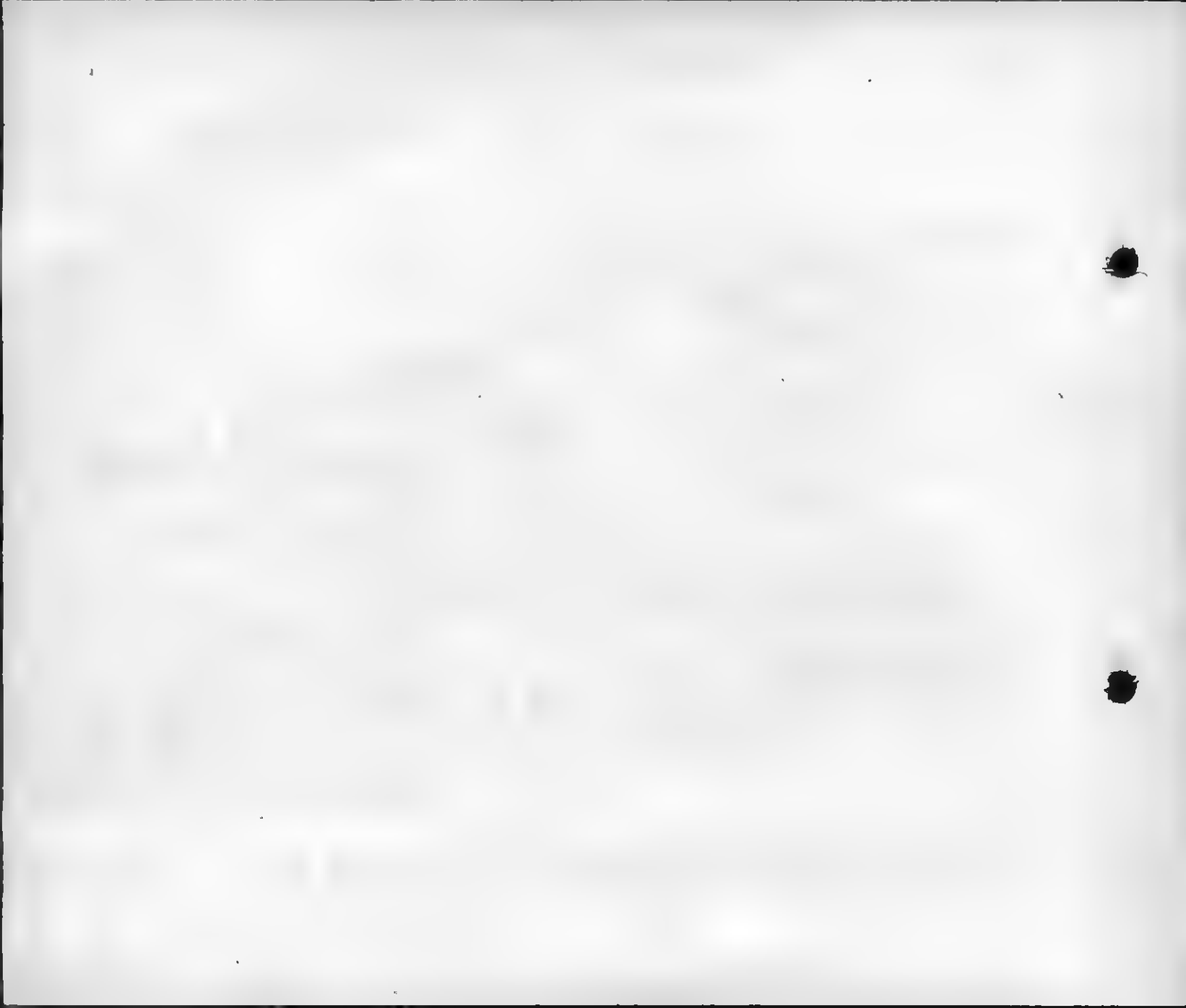
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>N. Meadow Drive</b>		d. STREET ADDRESS <b>1 N. Meadow DR.</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Ruby</b> Last <b>POBTHANN</b>		4. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 29-1901</b>
9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Engelhardt</b>		14. MOTHER'S MAIDEN NAME <b>Kate NAPP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension - race disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 25, 1958</b> , to <b>July 26, 1958</b> , that I last saw the deceased alive on <b>July 25, 1958</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip W. Keister</b> M.D.		ADDRESS (Street, city or town, state) <b>302 Victoria Ave Baltimore MD</b>	
PHYSICIAN'S NAME (Type) <b>KEISTER</b>		DATE SIGNED <b>July 25 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-29-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home 130 E Fort Ave</b>		24a. REC'D BY REGISTRAR <b>DATE 29 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Qu...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the separate burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07572

Reg. Dist. No.

7592

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN b <b>3 y 4 m 19 d</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Javisville</b> d. STREET ADDRESS <b>Javisville P. O.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Samuel</b> Last <b>Queen</b>		4. DATE OF DEATH Month <b>7</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-01</b>
9. AGE (In years lost birthday) <b>56</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Queen</b>	
14. MOTHER'S MAIDEN NAME <b>Henrietta</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>Hospital Records</b> Address <b>_____</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease/Hypertension</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Infarctive Myocardial Fibrosis</b> DUE TO (c) <b>Coronary and Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>_____</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>	20f. (City or town) (County) (State) <b>_____</b>
21. I certify that I attended the deceased from <b>3-2</b> , 19 <b>55</b> , to <b>7-21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-21</b> , 19 <b>58</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>7/21/58</b>			
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D. <b>Crownsville State Hospital, Md.</b> 7/21/58			
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b> <b>Crownsville State Hospital, Md.</b> 7/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>7/24/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CPD FELLOWS</b>	22d. LOCATION (City, town, or county) (State) <b>Chesapeake Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James C. Chinn</b> ADDRESS <b>Chesapeake Va</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>_____</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07573

7593

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN HAVEN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN HAVEN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3RD. STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>MILDRED</u> Last <u>ROGERS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWOMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>ERNESTINE WERNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>WILLIAM HARRY ROGERS</u>		Address <u>GREEN HAVEN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRONCHITIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> to <u>JULY 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JULY 13</u> , 19 <u>58</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		DATE SIGNED <u>7/8/58</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		ADDRESS (Street, city or town, state) <u>RIVIERA BEACH, PASADENA, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARK WOODGEM</u>	22d. LOCATION (City, town, or county) (State) <u>SALTO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harley Miller</u>		24a. REC'D BY REGISTRAR <u>9</u> DATE <u>7/9/58</u>	
ADDRESS <u>2334 Jefferson</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

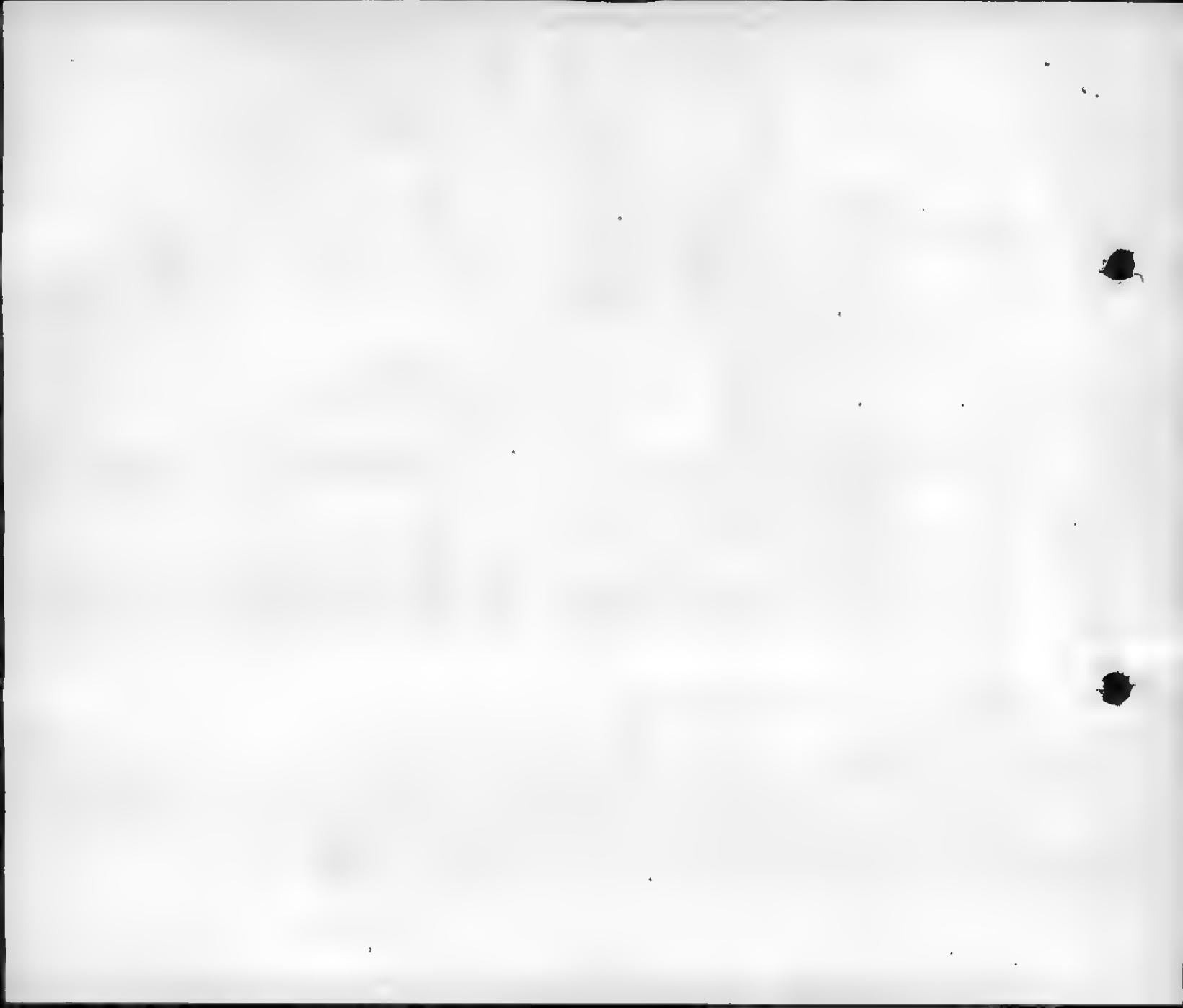
7594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07574

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Weldon's Restaurant, Mt. Pleasant,</u>		d. STREET ADDRESS <u>5520 Rubin Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Irvin Posenfeld</u>		4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>Morris Rosenfeld</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fleischman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Army II World War</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Earle Rosenfeld (brother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> s. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>7/10/58</u>	
NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Herrington Run</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joel Lewis Inc</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '58</u>	
ADDRESS <u>3100 Eastern Pl</u>		24b. REGISTRAR'S SIGNATURE <u>Al Lewis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7537 CERTIFICATE OF DEATH

Reg. Dist. No. 07575

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>113 Chesapeake Ave</u>				e. STREET ADDRESS <u>113 Chesapeake</u>			
3. NAME OF DECEASED (Type or print) <u>Florence</u> First <u>Russell</u> Middle <u>Russell</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-24-1904</u> 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Womb</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dr Connel &amp; Russell</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> DUE TO <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u> DUE TO (c) <u>Carcinoma of Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1954</u> to <u>July 28, 1958</u> , that I last saw the deceased alive on <u>7-28, 1958</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis Md</u> DATE SIGNED <u>7/27/58</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. T aylor</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Ann</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7595

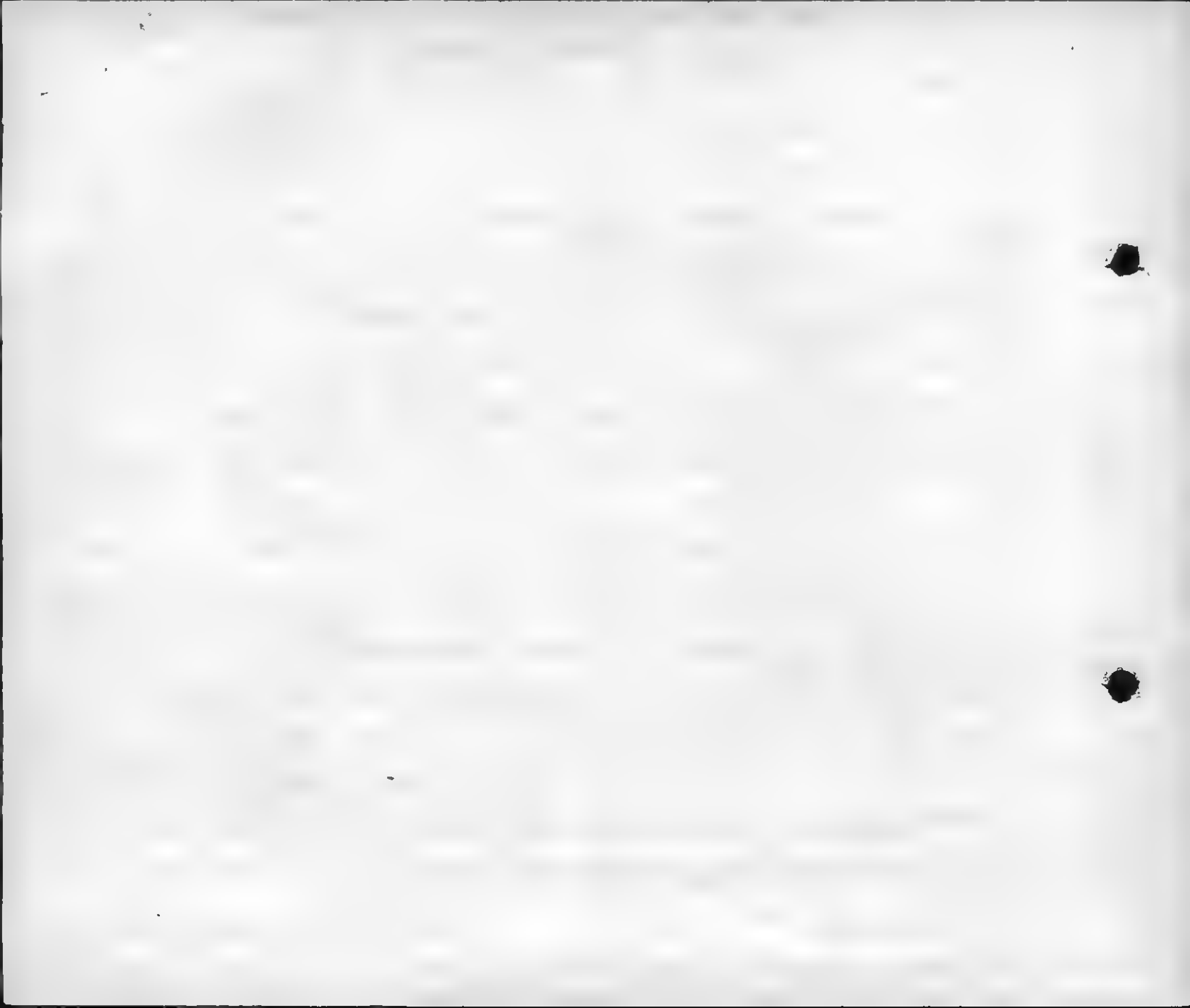
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RD - Rock View Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RD - Rock View Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 8 - Box 354</u>		d. STREET ADDRESS <u>Rt. 8 - Box 354</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Schreiber</u>		4. DATE OF DEATH July 3, 1958	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Protzman Bros.</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthias Schreiber</u>		14. MOTHER'S MAIDEN NAME <u>Adele (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Evelyn M. Schreiber</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>2 years</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1955, to <u>July 3</u> , 1958, that I last saw the deceased alive on <u>July 2</u> , 1958, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur Lankford Jr</u>		ADDRESS (Street, city or town, state) <u>Mountain Rd Pasadena Md.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR, MOUNTAIN RD. PASADENA MD.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 5, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md</u>	
24a. REC'D BY REGISTRAR <u>1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

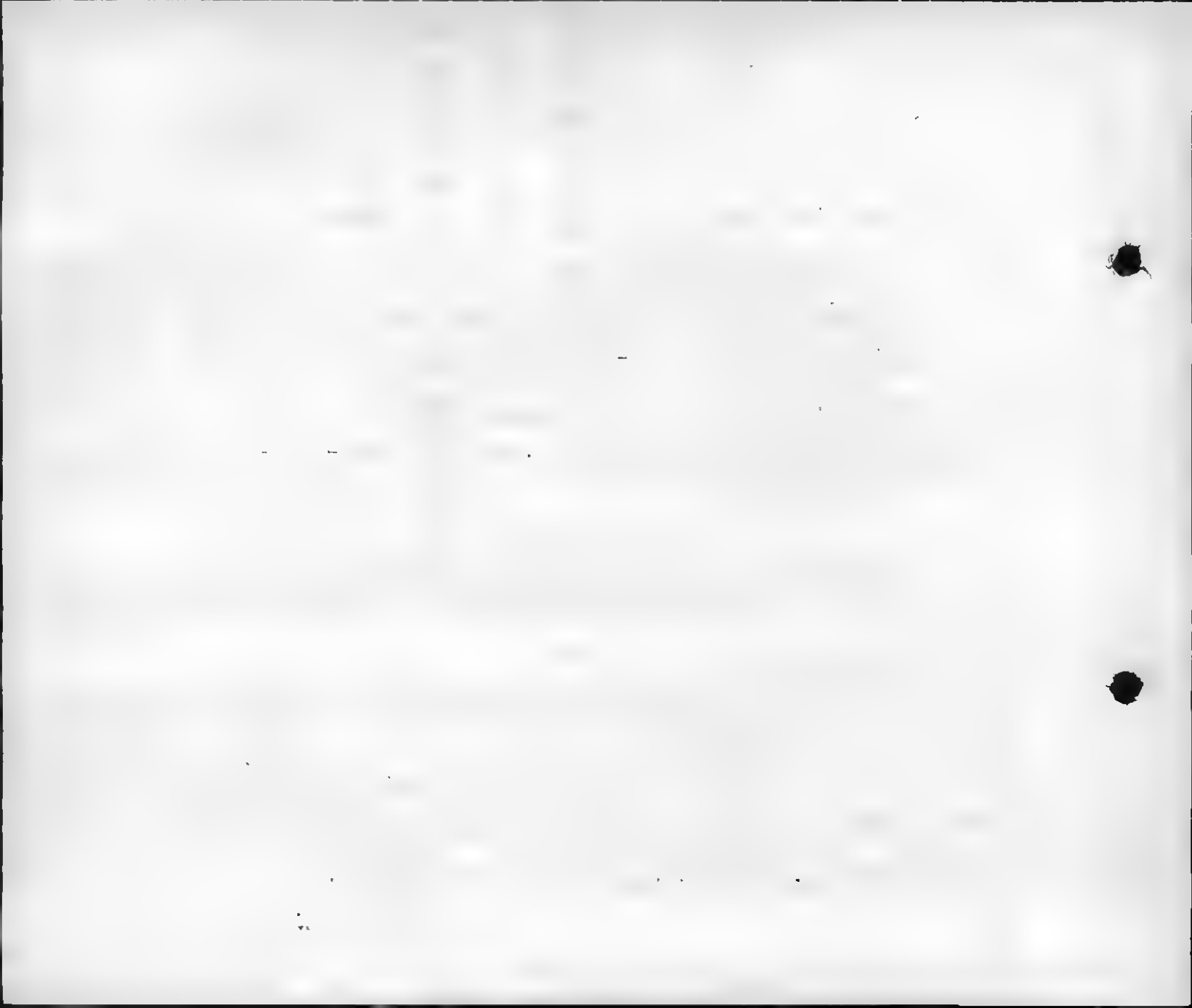


## 7538 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 Conduit Street</b>		d. STREET ADDRESS <b>124 Conduit Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM TILGHMAN SCIBLE</b>		4. DATE OF DEATH Month Day Year <b>JULY 25 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1880</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clerk-Drug store</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William T. Scible</b>		14. MOTHER'S MAIDEN NAME <b>Emma Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>213-34-3387</b>	
17. INFORMANT <b>Mrs. Mary L. Scible - Wife - same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BR - 25:100 PNEUMONIA</b> <b>441X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIO-SCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 12, 1958</b> to <b>July 25, 1958</b> , that I last saw the deceased alive on <b>July 25, 1958</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward S. Beck</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Southgate Ave., Annapolis, Maryland</b> <b>7/25/58</b>	
PHYSICIAN'S NAME (Type) <b>Edward S. Beck M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>July 28, 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>	
ADDRESS <b>Annapolis, Maryland</b>		24. REC'D BY REGISTRAR <b>JUL 29 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Ed. Beck</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The form has been signed by the attending physician and completely filled out. Page 2 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07578

CERTIFICATE OF DEATH

7596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY in 1b <b>2yrs. 12days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
3. NAME OF DECEASED (Type or print) <b>Finney</b>				d. STREET ADDRESS <b>1120 Barclay</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1891</b>	
9. AGE (In years last birthday) <b>67</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>AHCVD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old left hemiplegia - Chronic Brain Syndrome Associated with AHCVD</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>Known for 2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>July 19, 1956</b> to <b>7/31/ 19 58</b> , that I last saw the deceased alive on <b>7/31/ 19 58</b> , and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Hildegard Heard Reisman</b> M.D. <b>Crownsville State Hospital, Md.</b>				DATE SIGNED <b>8/1/58</b>			
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reisman, M. D. Crownsville State Hospital, Md.</b>				DATE <b>8/1/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-5-58</b>		22c. NAME OF CEMETERY OF CREMATORY <b>W. H. Md.</b>		22d. LOCATION (City, town, or county) <b>Balto.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. Ann. Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>Aug 6 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	



7597

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Lillian S Shaw</u>		4. DATE OF DEATH <u>7 25 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-1910</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Shadyside, Md.</u>	
12. FATHER'S NAME <u>Herman Nick</u>		13. MOTHER'S MAIDEN NAME <u>Grace Scott</u>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		15. SOCIAL SECURITY NO. <u>—</u>	
16. INFORMANT <u>George Shaw</u>		17. ADDRESS <u>Shadyside, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Carcinoma of left lung</u> (b) <u>6 months</u> (c) <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1958</u> to <u>June 25, 1958</u> that I last saw the deceased alive on <u>June 25, 1958</u> , and that death occurred at <u>110-CLAY ST BALTIMORE</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Reese</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST BALTIMORE</u>	
PHYSICIAN'S NAME (Type) <u>William Reese, M.D.</u>		DATE SIGNED <u>7/26/58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Scotts</u>	22d. LOCATION (City, town, or county) (State) <u>Shadyside, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>28 58</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7598 CERTIFICATE OF DEATH

07580

Reg. Dist. No.

1. PLACE OF DEATH <del>Place=Manor=Nursing=Home</del> a. COUNTY <b>Ann Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) 1808 E. Hoffman St. b. COUNTY <b>Balto. Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Olivia Sheldon</b>		4. DATE OF DEATH <b>July 31, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ind.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas J. Preston</b>		14. MOTHER'S MAIDEN NAME <b>Annie Peters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Andrew Preston</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic brain syndrome, asso. with senile brain disease.</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>13 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nontoxic nodular goiter, hypothyroidism due to unknown cause.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 13</b> , 19 <b>57</b> to <b>July 31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 27</b> , 19 <b>58</b> , and that death occurred at <b>4:30 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James M. Pair</b>		ADDRESS (Street, city or town, state) <b>400 N. Carrollton Ave. Balto. 23, Md. 8.1.58</b>	
PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3 Aug. 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Private</b>	22d. LOCATION (City town or county) (State) <b>White Haven Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. Wainwright</b>		24a. REC'D BY REGISTRAR <b>Aug 4, 1958</b>	
ADDRESS <b>2700 Edmondson Ave</b>		24b. REGISTRAR'S SIGNATURE <b>W. Deane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

07581

7539

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP.</u>				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM C. SHOEMAKER</u>				4. DATE OF DEATH Month Day Year <u>JULY 17 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 8 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Odenton Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALFRED SHOEMAKER</u>				14. MOTHER'S MAIDEN NAME <u>MARY BELL COBB</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>955 82 290</u>		17. INFORMANT Address <u>4710 26th St. NE Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEPHRITIS + CEREBRAL THROMBOSIS</u> <u>440 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Strangulated umbilical hernia + mild diabetes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/25/58</u> to <u>7/17/58</u> that I last saw the deceased alive on <u>7/17/58</u> and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D.				<u>98 Cathedral St. 7/19/58</u>			
PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS</u>				<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlands</u>		22d. LOCATION (City, town or county) (State) <u>Kidlesville P.A. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Kidlesville Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 22 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7540 CERTIFICATE OF DEATH

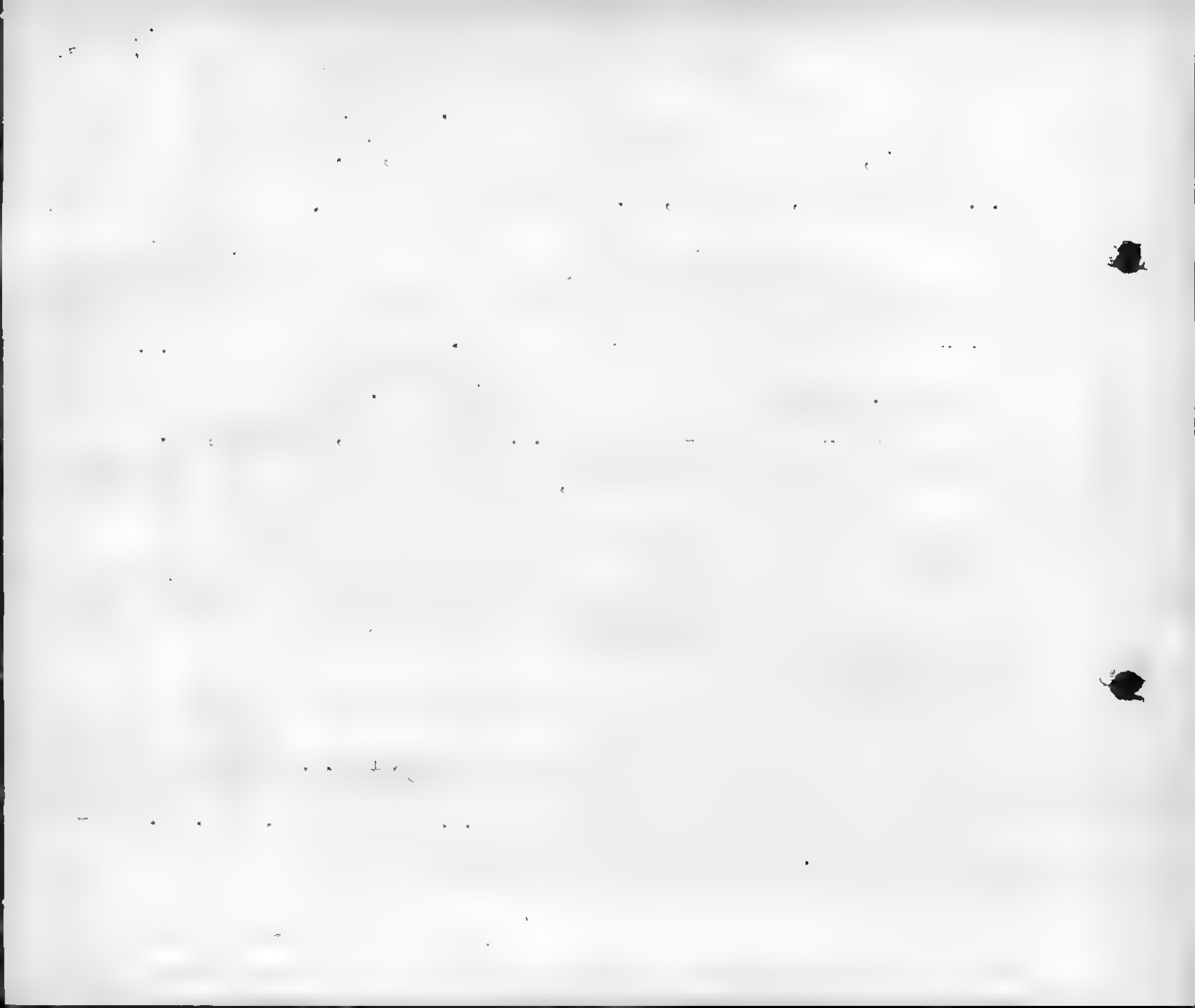
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Md.</b>			
c. LENGTH OF STAY IN lb <b>Newborn</b>				d. STREET ADDRESS <b>1501 Bay Ridge Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Annapolis, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Baby Girl</b> Middle <b>SMITH</b> Last <b>SMITH</b>		4. DATE OF DEATH		Month <b>July</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 July 1958</b>		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Franklin D. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth M. PEREGOV</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. ---		17. INFORMANT <b>U.S. Naval Hospital, Annapolis, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>752 x HYDROCEPHALUS, CONGENITAL</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myelomeningocele and Multiple congenital defects</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 July 1958</b> , to <b>16 July 1958</b> , that I last saw the deceased alive on <b>16 July 1958</b> , and that death occurred at <b>10:50 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Anna. Md. 7-17-58</b>							
ACTUAL SIGNATURE <b>Francisco J. S. S.</b> M.D.				PHYSICIAN'S NAME (Type) <b>LCDR F. (N) DEPAOLA MC USN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7-18-58</b>		<b>Naval Academy</b>		<b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sues</b>				ADDRESS <b>Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Quel...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7541 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>10</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DOA Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b> d. STREET ADDRESS <b>1020 Bay Ridge Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GU Y W STALLINGS</b>		4. DATE OF DEATH Month Day Year <b>JULY 30 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Bryan Stallings</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Norfolk</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>219-01-8946</b>		17. INFORMANT Address <b>Mrs Virginia Satllings, Wife- Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dilatation of the heart</b> DUE TO <b>Coronary Occlusion.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Immediate</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(None)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 10, 1958</b> to <b>July 10, 1958</b> , that I last saw the deceased alive on <b>P. O. A</b> , 19 <b>58</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Albert L. Anderson</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>44 Southgate Ave. - Annapolis, Md. - 7/1/58</b>	
PHYSICIAN'S NAME (Type) <b>Albert L. Anderson MD</b>		Southgate Ave. Annapolis, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 12, 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>July 14 '58</b>
24b. REGISTRAR'S SIGNATURE <b>Albert L. Anderson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7542 CERTIFICATE OF DEATH

07584

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Annapolis Gen. Hosp</i>				1 d. STREET ADDRESS <i>107 Club Rd. RT6</i>			
3. NAME OF DECEASED (Type or print) First <i>Lloyd</i> Middle <i>H.</i> Last <i>Stern</i>				4. DATE OF DEATH Month <i>7</i> Day <i>19</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27, 1920</i>	9. AGE (In years last birthday) <i>37</i> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Refectores Co</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Dewey Stern</i>				14. MOTHER'S MAIDEN NAME <i>Helena Rose Miller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>172-18-2744</i>		17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intoxicating perspiration</i> <i>Secondary</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchogenic Carcinoma</i> DUE TO (c) <i>?</i>							INTERVAL BETWEEN ONSET AND DEATH <i>72-hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>— 19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>7-19-58</i> 19 <i>58</i> to <i>7-19-58</i> 19 <i>58</i> , that I last saw the deceased alive on <i>7-19-58</i> 19 <i>58</i> , and that death occurred at <i>11 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank M Shipley</i> M.D.				ADDRESS (Street, city or town, state) <i>121 E 24th St. Baltimore, Md.</i>			
DATE SIGNED <i>7-20-58</i>							
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>				<i>Annapolis, Md.</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7-23-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>National Cem</i>		22d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCarthy Funeral Home</i>				ADDRESS <i>1305 Fox ave.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 22 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Alb. Leach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7593 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY in 1b <u>3 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lanns Nursing Home</u>		d. STREET ADDRESS <u>29 Bataspaco Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>WILLIAM</u> <u>H. STINCHCOMB</u>		4. DATE OF DEATH <u>July</u> <u>13</u> <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1907</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRODUCE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William V. Stinchcomb</u>		14. MOTHER'S MARDEN NAME <u>Clara Burke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-09-5762</u>	
17. INFORMANT <u>Jean Williams</u>		Address <u>Millersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 22-58</u> to <u>July 13-58</u> , that I last saw the deceased alive on <u>July 13-58</u> , 19 <u>58</u> , and that death occurred at <u>11:30 a.m.</u> from the causes and on the date stated above.		ADDRESS (Street, city, town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE OF INTERMENT <u>July 16, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn P.D., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. V. Kingston</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 17 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



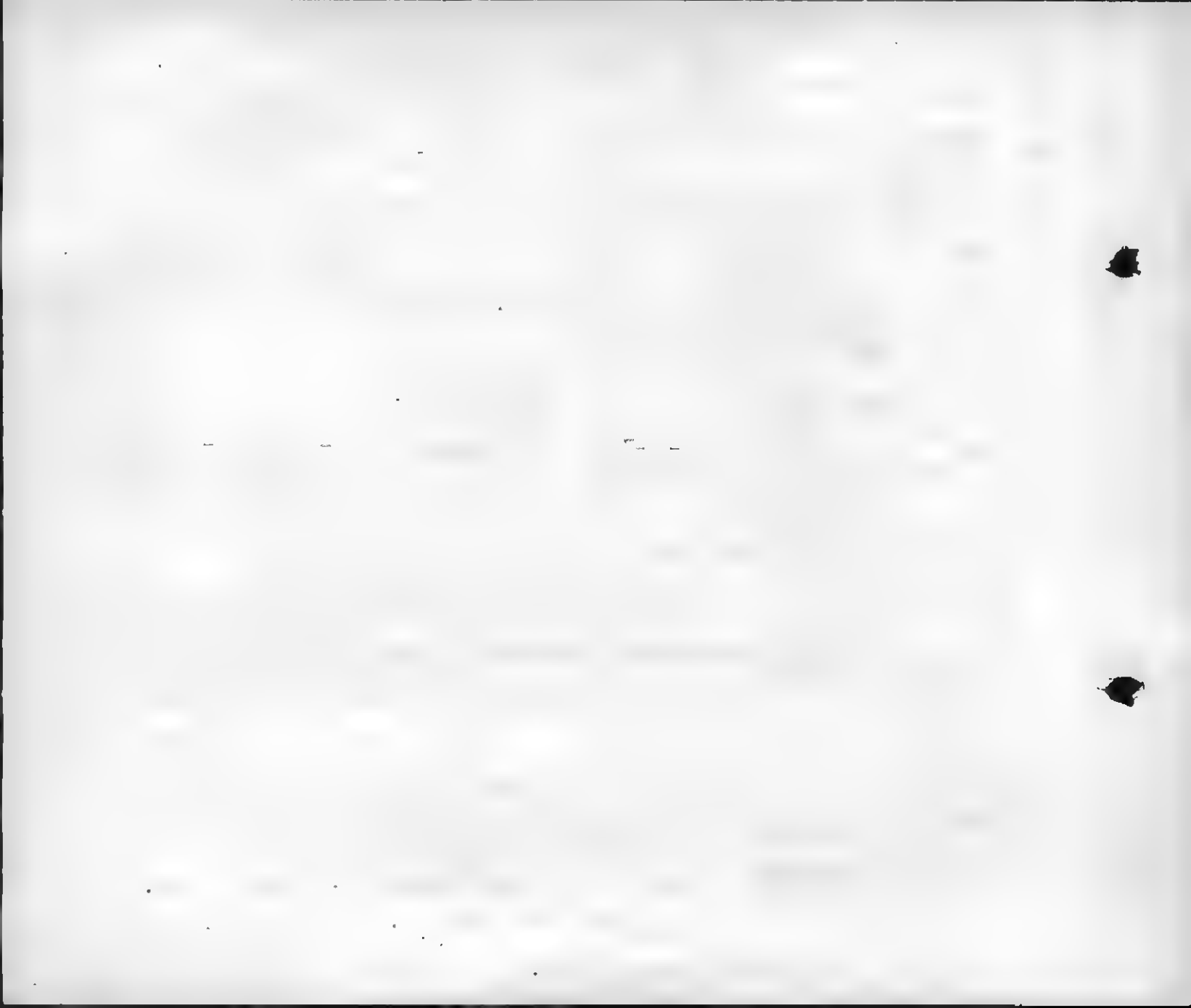
## 7543 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before adm'ion) a. State <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>J</u> Last <u>STONE</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1901</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	11. IF UNDER 24 HRS Hours <u>6</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel Bar</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Alloway</u>		14. MOTHER'S MAIDEN NAME <u>Kate Enens</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-20-7042</u>	
17. INFORMANT <u>Lela Katherine Stone- Daughter- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INCREASED INTRACRANIAL PRESSURE</u> <u>163X</u> DUE TO (b) <u>CEREBRAL METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CARCINOMA OF LUNG</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>6 hrs</u> <u>3 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 7, 1958</u> to <u>7/7, 1958</u> , that I last saw the deceased alive on <u>7/7, 1958</u> , and that death occurred at <u>7:24</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Beck</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/15/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward Beck</u>		Southgate Ave., Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 10 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Alberich</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7600 CERTIFICATE OF DEATH

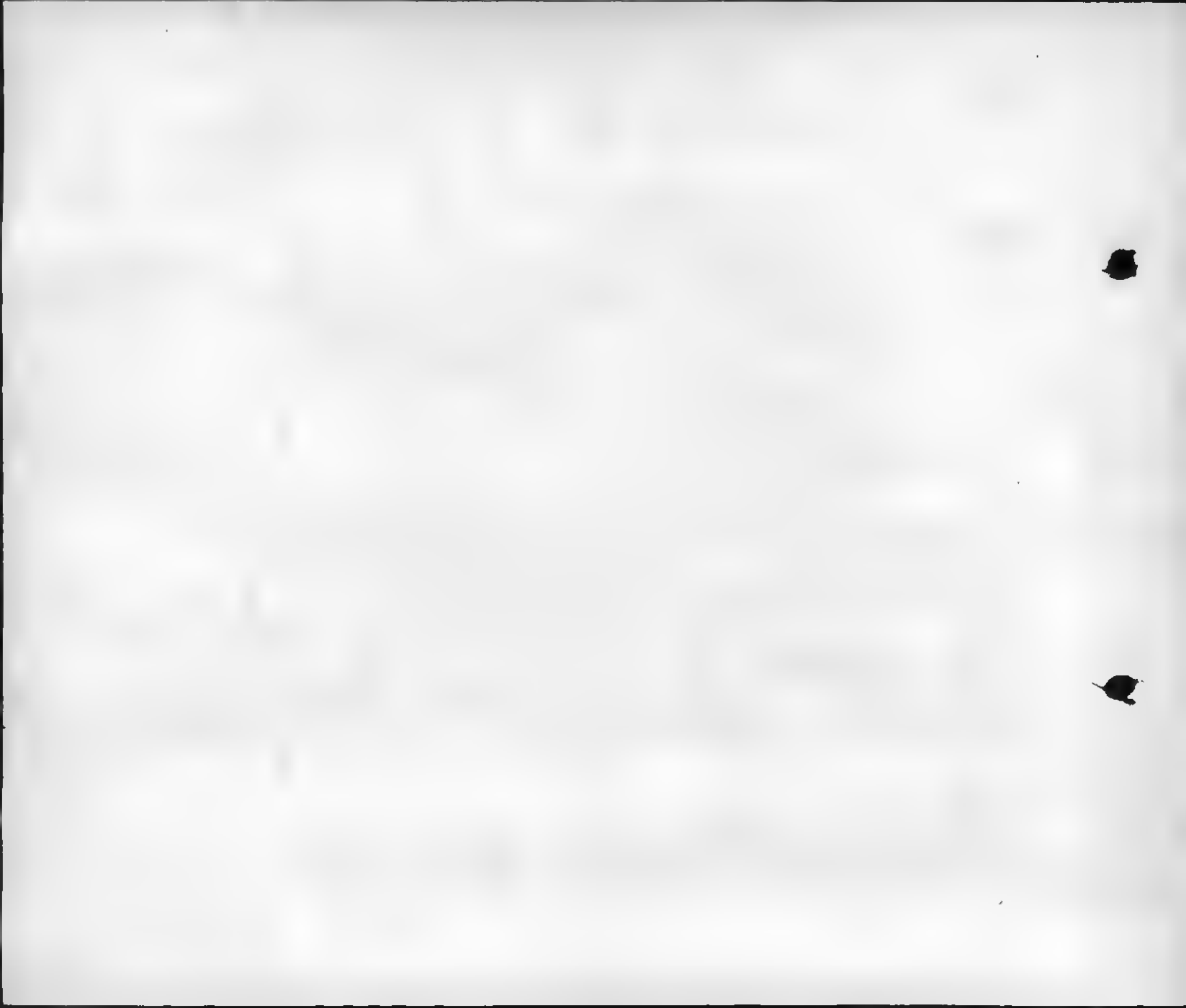
Reg. Dist. 07587

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Grove Park Rd.</u>				d. STREET ADDRESS <u>1206 Grove Park Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>F.</u> Last <u>Sturgeon</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1895</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eyerly</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Kimble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Norman Sturgeon</u>		Address <u>206 Grove Park Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260X Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>atherosclerosis, generalized</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9/2</u> 19 <u>57</u> to <u>7/2</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7/2</u> 19 <u>58</u> , and that death occurred at <u>4:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norton M. Krieger</u> M.D.				ADDRESS (Street, city or town, state) <u>5010 A Ritchie Highway</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>NORTON M. KRIEGER</u>				ADDRESS <u>5010 A RITCHIE HWY. MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/6/58</u>		<u>New Cathedral Cem.</u>		<u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u> ADDRESS <u>2431-35 E. Oliver St.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7601

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Neenah</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bundy Beach</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase - 1 mi.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Anne Arundel General</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Szorensk</i> Last <i>Szorensk</i>				4. DATE OF DEATH Month <i>July</i> Day <i>4</i> Year <i>1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 11, 1935</i>	9. AGE (In years last birthday) <i>22 yrs.</i>	10. IF UNDER 1 YEAR Months <i>22</i> Days <i>4</i> Hours <i>19</i> Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mathematician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Natl Ins Co -</i>		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>Hungarian</i>	
13. FATHER'S NAME <i>George Szorensk</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>57754-3820</i>		17. INFORMANT <i>Wife - 5792-144 S.E.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>drowning</i> <i>929.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>due to</i> (c) <i>due to</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Interval between onset and death</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Swimming</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>5:30 p.m.</i> <i>July 4</i> 19 <i>58</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bundy Beach</i>		20f. (City or town) (County) (State) <i>Cherry Chase</i> <i>AA</i> <i>Ind.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Emil H. Kulajn</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-9-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Regina A. Kask - 741-11th St. S.E.</i>				24a. REC'D BY REGISTRAR DATE <i>9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



## 2602 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>3y 7m 11d</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>718 Vine Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie</b> First Middle Last <b>Terry</b>		4. DATE OF DEATH Month Day Year <b>7 28 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia with Hypostatic Pneumonia</b> <b>4344</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiac Decompensation with old Myocardial Infarct</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia with Decubitus Ulcers</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1956</b> to <b>July 28 1958</b> , that I last saw the deceased alive on <b>July 28 1958</b> , and that death occurred at <b>2:20 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Crownsville State Hospital, Md. 7/30/58</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md. 7/30/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Removal</b>		<b>7-31-58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Woods Md.</b>		<b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>William Reese, Jr. Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 1 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. Seach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7544 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>47 Pleasant Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patricia Ann Shreath</u>			4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-1958</u>		9. AGE (In years last birthday) yrs <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u>5</u> Min <u></u>	IF UNDER 24 HRS Hours <u>5</u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert B. Shreath</u>			14. MOTHER'S MAIDEN NAME <u>Scarola Butler</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert B. Shreath</u> Address <u>47 Pleasant St</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> 774x DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>471X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u></u>	Month <u>7</u>	Day <u>27</u>	Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>47 Pleasant St</u>	20f. (City or town) <u>Annapolis</u> (County) <u>Ad.</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>July 6, 1958</u> to <u>July 27, 1958</u> , that I last saw the deceased alive on <u>July 27, 1958</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>			ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u> DATE SIGNED <u>7/29/58</u>				
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beverly Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Kress #108 Wash St Annapolis</u>			ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>JUL 29 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. Kress</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

7603

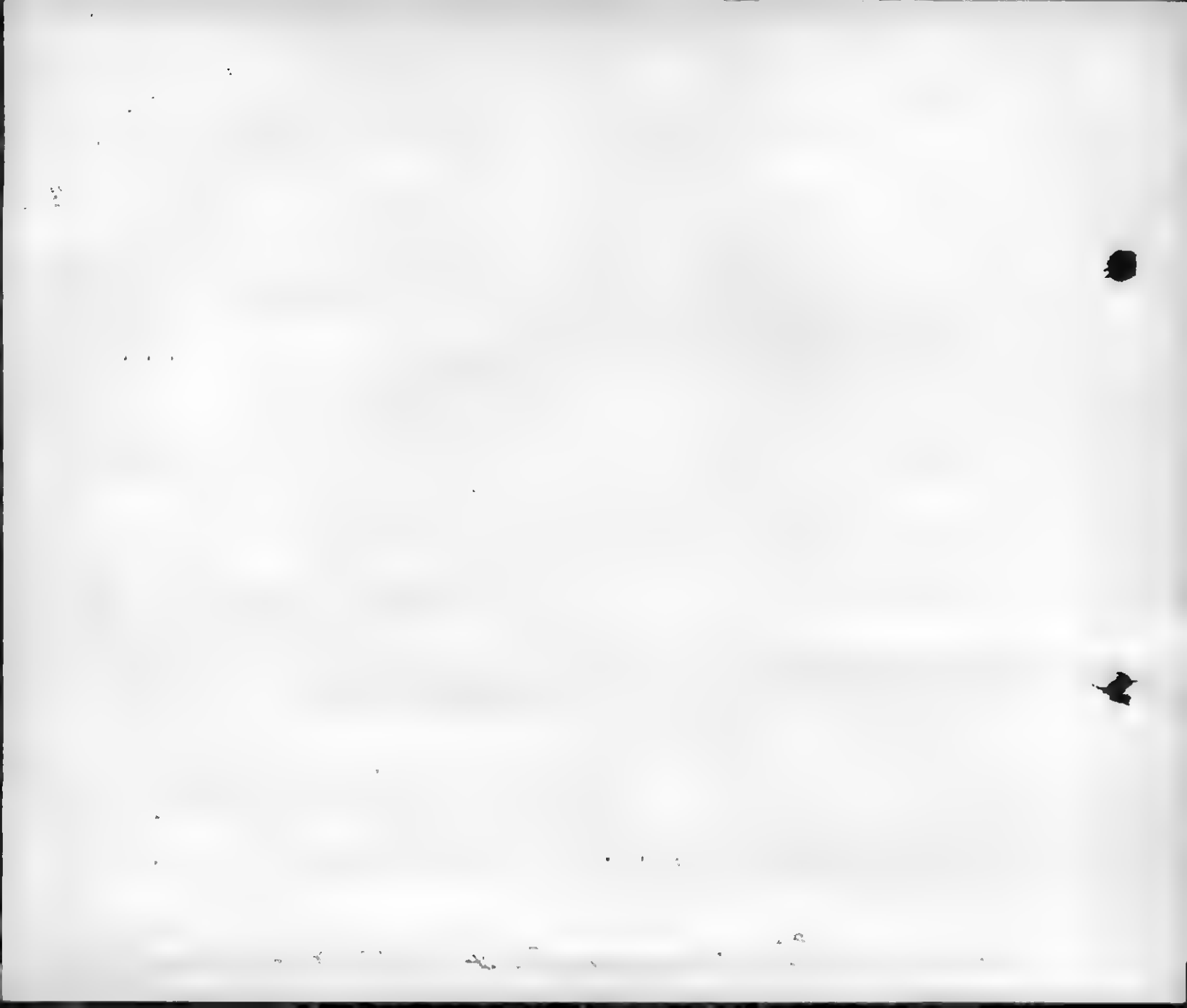
## CERTIFICATE OF DEATH

Reg. Dist. No. 07591

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2y 6m 13 d</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1308 Argyle Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie</b>		4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1892 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia - Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 19 56</b> to <b>July 3 19 58</b> , that I last saw the deceased alive on <b>July 3, 19 58</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>Lionel McHenry Mapp, M.D.</b> Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1</b>		22b. DATE THEREOF <b>7-8-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>
22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>#2</b> <b>W. M. STEAR</b> ADDRESS <b>108 Washington St</b>	
24a. REC'D BY REGISTRAR <b>7-8-58</b>		24b. REGISTRAR'S SIGNATURE <b>W. M. STEAR #2</b>	

JUL 10 '58





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

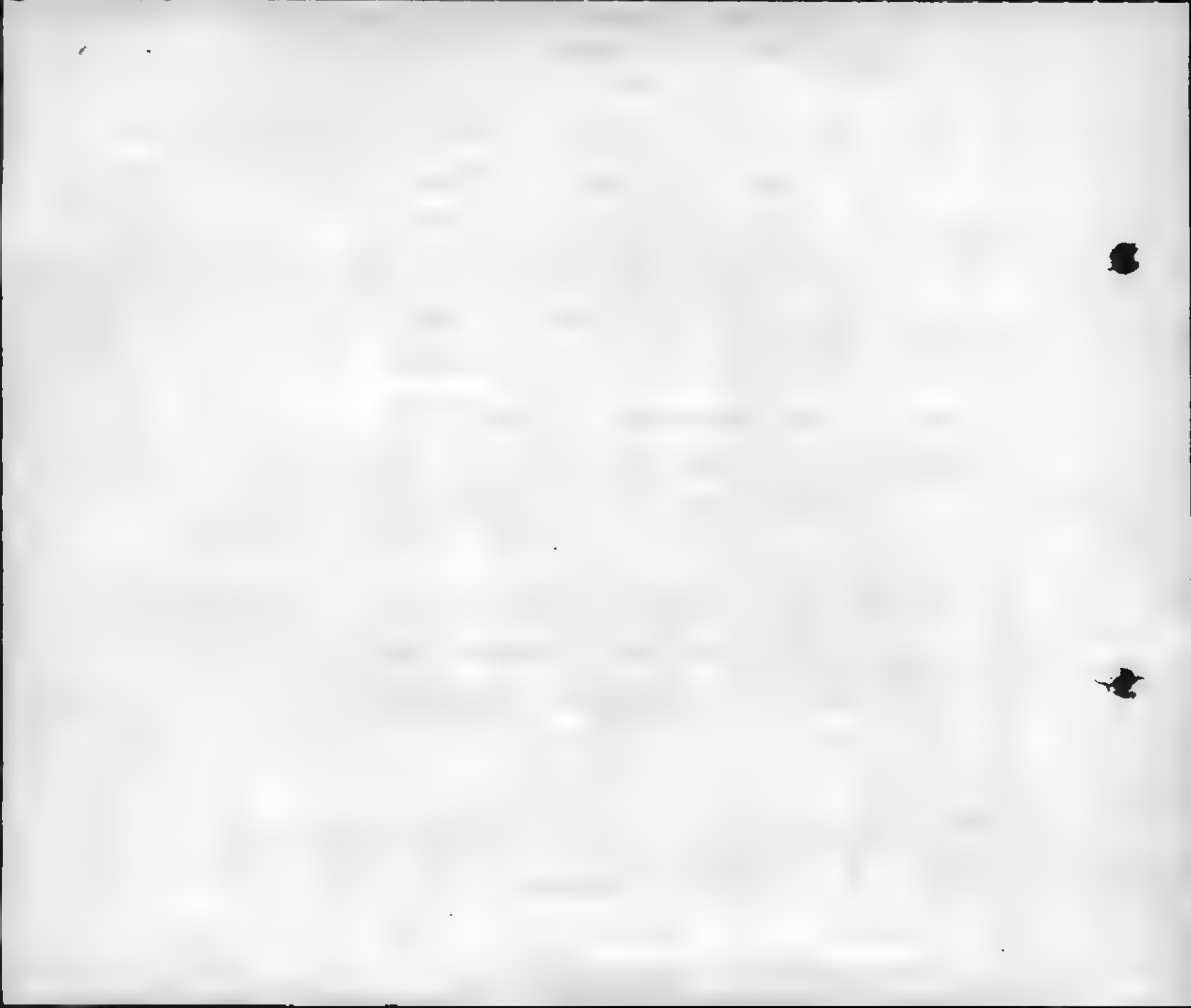
07592

7545

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.M. Anne Arundel General</u>				d. STREET ADDRESS <u>Carrollton - Ave 527</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Tilmond</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1911</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jim Jones</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Oscar Dunk - Lumbly Mt.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>o. m.</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>7/23/58</u>			
EXAMINER'S NAME (Type) <u>F. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>7/26/1958</u>	<u>St. John's Lutheran</u>		<u>St. John's Lutheran</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Kate Williams</u>		ADDRESS <u>Schroeder St</u>		24a. REC'D BY REGISTRAR <u>JUL 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GEN</u>		d. STREET ADDRESS <u>631 W. LEE ST</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Torney</u> Middle Last		4. DATE OF DEATH <u>7-19-1958</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/1888</u> 9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. CONTRACT</u>	
11. BIRTHPLACE (State or foreign country) <u>GLVERT CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH TORNEY</u>		14. MOTHER'S MAIDEN NAME <u>JANE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>ANNIE H. MARTIN</u> Address <u>631 W. LEE ST</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> (c) <u>                    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Boat Capsized</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:10</u> Hour <u>7/19/58</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>water</u>		20f. (City or town) <u>Chesapeake Bay</u> (County) <u>Anne Arundel Co.</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William J. Ford</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-20-58</u>	
EXAMINER'S NAME (Type) <u>William J. Ford</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL OR CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's Church</u>		22d. LOCATION (City, town, or county) <u>Calvert Co. MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Ayers</u>		24a. REC'D BY REGISTRAR <u>                    </u> 24b. REGISTRAR'S SIGNATURE <u>                    </u>	

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

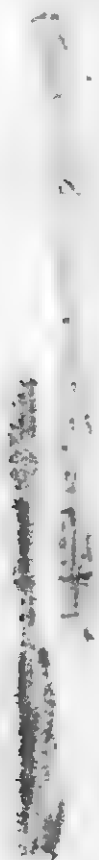
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7604 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Plaza Manor Nursing Home</b>		e. STREET ADDRESS <b>608 Eislens St.</b>	
3. NAME OF DECEASED (Type or print) <b>Charles N. Tucker</b>		4. DATE OF DEATH <b>July 2nd. 19 58</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/80</b>
9. AGE (In years less birthday) <b>77 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>27</b> Hours <b>19</b> Min <b>58</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Tucker</b>		14. MOTHER'S MAIDEN NAME <b>Laura Simmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>Plaza Manor Records</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Asthenia</b> <b>194X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		18. INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		DATE SIGNED <b>7/2/58</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal of remains (Specify) <b>27/8/58</b>		22b. NAME OF CEMETERY OR CREMATORY <b>mt Auburn</b>	
22c. LOCATION (City, town, or county) <b>Baltimore</b>		22d. REGISTRAR'S SIGNATURE <i>Charles A. Rice</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Rice</i>		24. REC'D BY REGISTRAR DATE <b>JUL 8 '58</b>	



7605

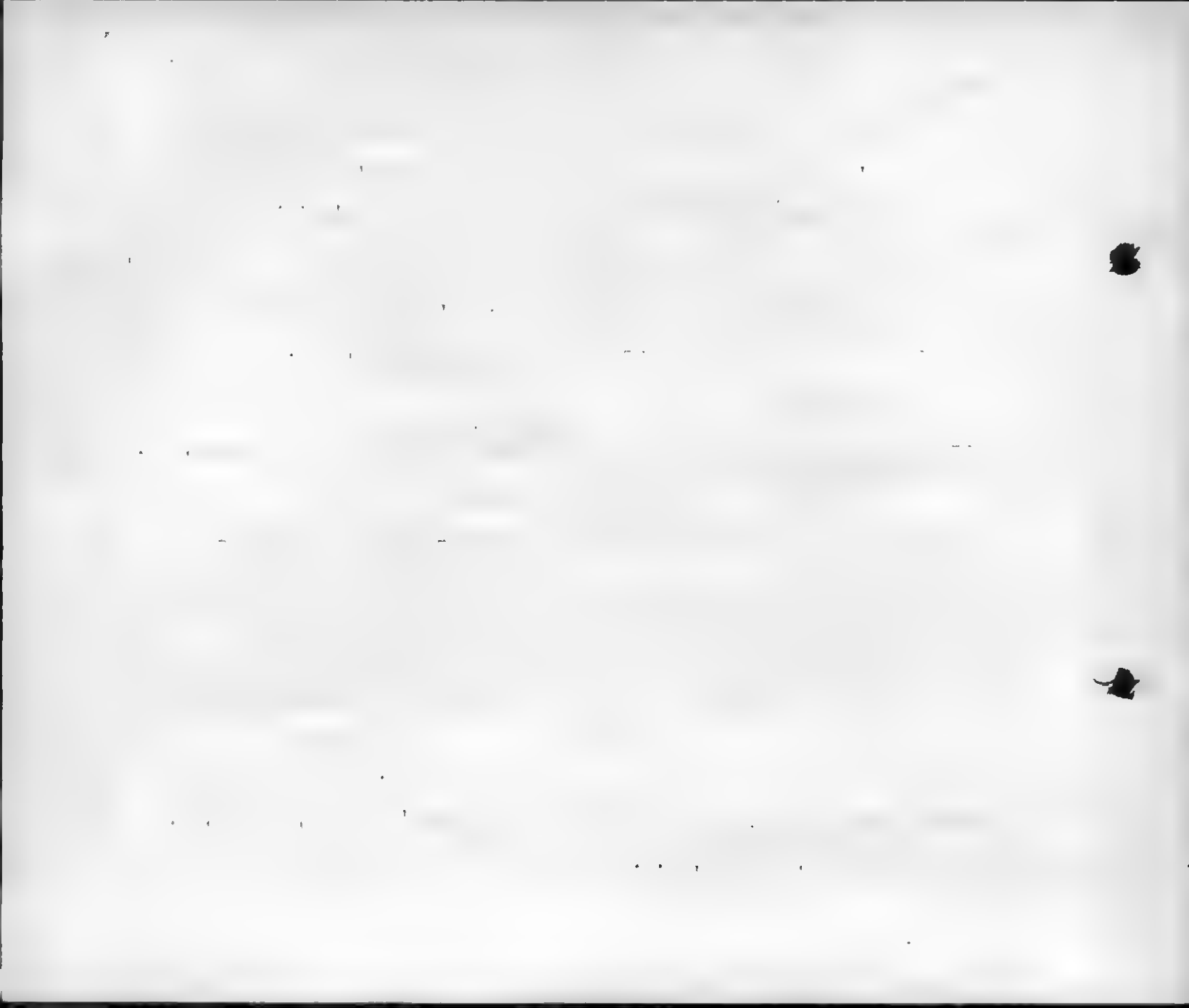
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>		c LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>District Training School Children's Center</b>		e STREET ADDRESS <b>217 V Street, N.W.</b>		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>BRIAN</b> Middle <b>UNDERWOOD</b> Last		4 DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 24, 1950</b>	9 AGE (In years last birthday) <b>7</b> yrs	IF UNDER 1 YEAR: Months <b>7</b> Days <b>8</b> Hours <b>14</b> Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Bruce Underwood</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Elizabeth Hawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16 SOCIAL SECURITY NO <b>--</b>		17. INFORMANT <b>District Training School Children's Center</b> Address <b>Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>aspiration pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>spastic quadriplegia-mental retardation-severe</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks from birth</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4/11/58</b>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>6/14/57</b> , 19____, to <b>7/14/58</b> , 19____, that I last saw the deceased alive on <b>7/14/58</b> , 19____, and that death occurred at <b>8:55 a.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b> DATE SIGNED <b>7/14/58</b>					
ACTUAL SIGNATURE <b>James E. Boyland, M.D.</b>		PHYSICIAN'S NAME (Type) <b>James E. Boyland, M.D.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>7-17-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Spangler</b>		ADDRESS <b>524-8-St NE</b>		24a REC'D BY REGISTRAR <b>DATE 15 '58</b>	24b REGISTRAR'S SIGNATURE <b>Wm. Spangler</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7547

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Unknown</u> b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Unknown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summerville Road</u>		d. STREET ADDRESS <u>unknown</u>	
3. NAME OF DECEASED (Type or print) <u>UNIDENTIFIED INFANT</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>?</u>	6. COLOR OR RACE <u>?</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Full Term</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined - Decomposed Infant</u> <u>795.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Paul F. Guorin</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Paul F. Guorin, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>CREMATED MORGUE</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



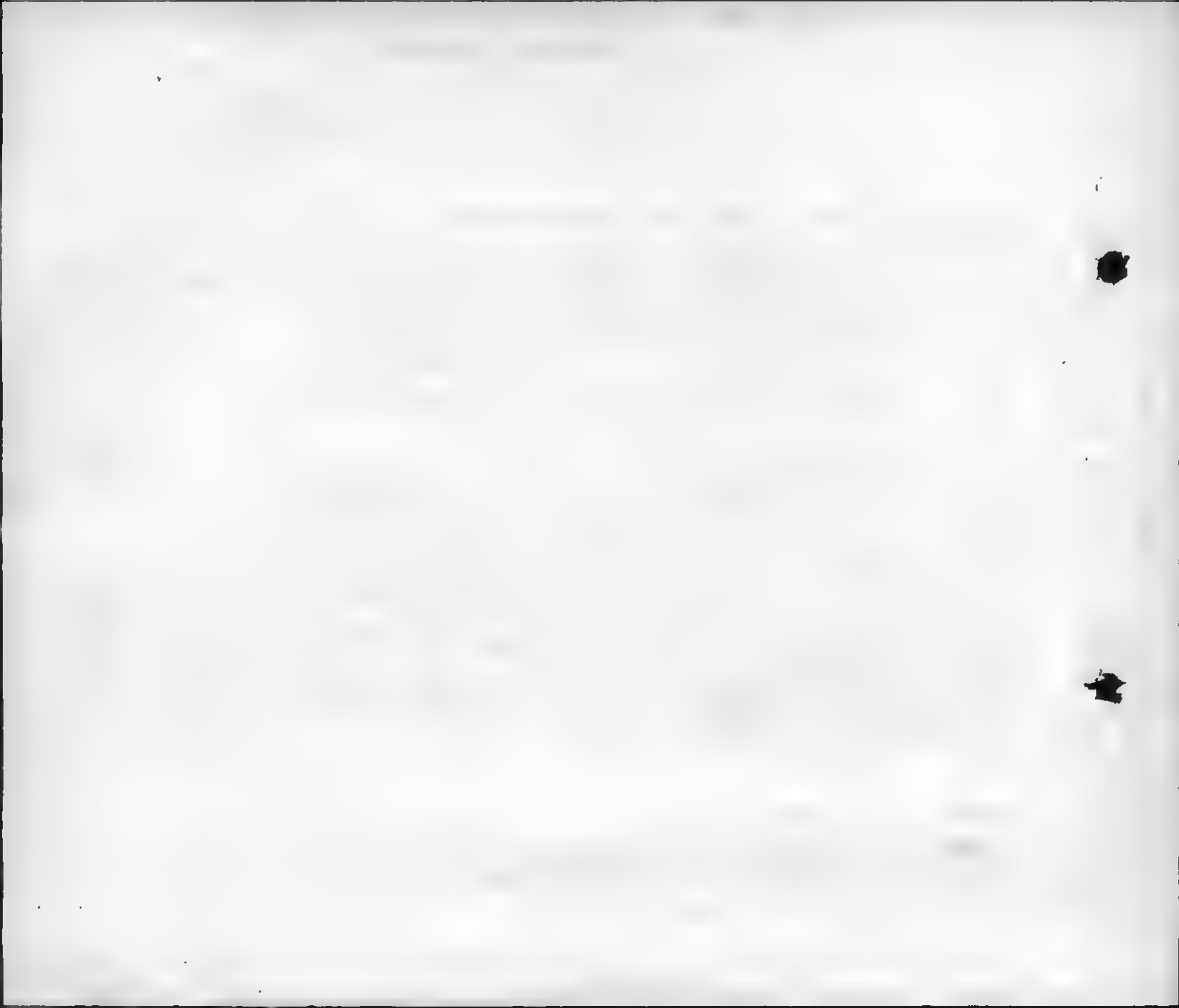
Reg. Dist. No. 07596

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STONEY BEACH, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2100 E. FERNHILL ROAD</u>		d. STREET ADDRESS <u>1500 W. HAMMANG</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WILLIAM JOSEPH VOYCE</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>JULY 26 1958</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>AUG. 6, 1879</u>
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ELEVATOR OPERATOR</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. CUSTOMS</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>George Voyce</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Lowe</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT.</b> <u>WILLIAM M. VOYCE</u>		Address <u>2100 E FERNHILL RD BALTO. 24, MD</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. _____ Month _____ Day _____ Year <u>19</u>	<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> _____ (County) _____ (State) _____
<b>21. I certify that</b> _____ attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>July 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>58</u> , and that death occurred at <u>6:40 P.</u> M., from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>J. Brady Smith</u>		<b>DATE SIGNED</b> <u>7/26/58</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>J. BRADY SMITH</u>		<b>ADDRESS</b> (Street, city or town, state) <u>Riviera Beach, Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>7/29/58</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Cross</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Ritchie Highway Balto. Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Schweinsberg Funeral Service 1126 W. Gros</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUL 29 '58</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>

1126 W. Cross St. Balto. 30 Md.



## CERTIFICATE OF DEATH

Reg. Dist. No. 07597

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPANN'S NURSING HOME</u>		d. STREET ADDRESS <u>ANNAPOLIS</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>M.</u> Last <u>WAGNER</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>(1891) 2/11/1891</u>
9. AGE <u>67</u> yrs. last birthday		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>17</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bartholomew - Tridion</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Jean Williams</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Bilateral Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked Obesity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased <u>July 22-58</u> , 19 <u>58</u> , to <u>July 24, 58</u> , that I last saw the deceased alive on <u>July 24-58</u> , 19 <u>58</u> , and that death occurred at <u>10:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>July 25-58</u>			
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKY</u>		PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKY</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 28, 58.</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

07598

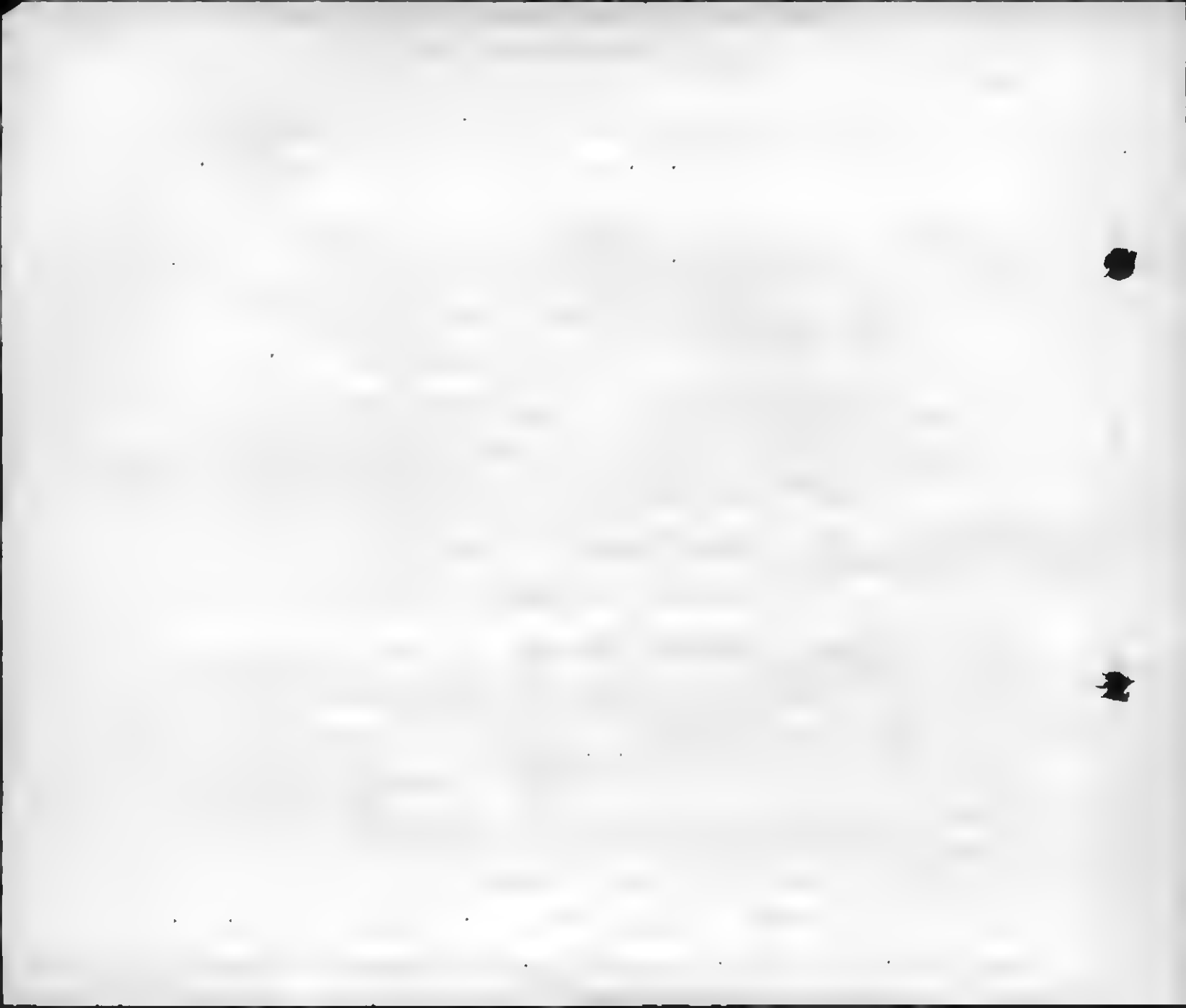
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lake Shore, Pasadena P. O.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lake Shore, Pasadena P. O., Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>H.</b> Last <b>Wehrheim</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Phillip Wehrheim</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-05-2255A</b>	
17. INFORMANT <b>Miss Margaret Wehrheim</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebral thrombosis</b> DUE TO <b>Arteriosclerotic cerebro-cardio-vascular disease 5 years.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cardiac decompensation</b> (c) <b>5 years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1958</b> to <b>July 12, 1958</b> , that I last saw the deceased alive on <b>July 11, 1958</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. M. McLaughlin</b> M.D.		ADDRESS (Street, city or town, state) <b>Pasadena, Maryland</b> DATE SIGNED <b>July 12, 1958</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, Inc.</b>		ADDRESS <b>715 Light St.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07599

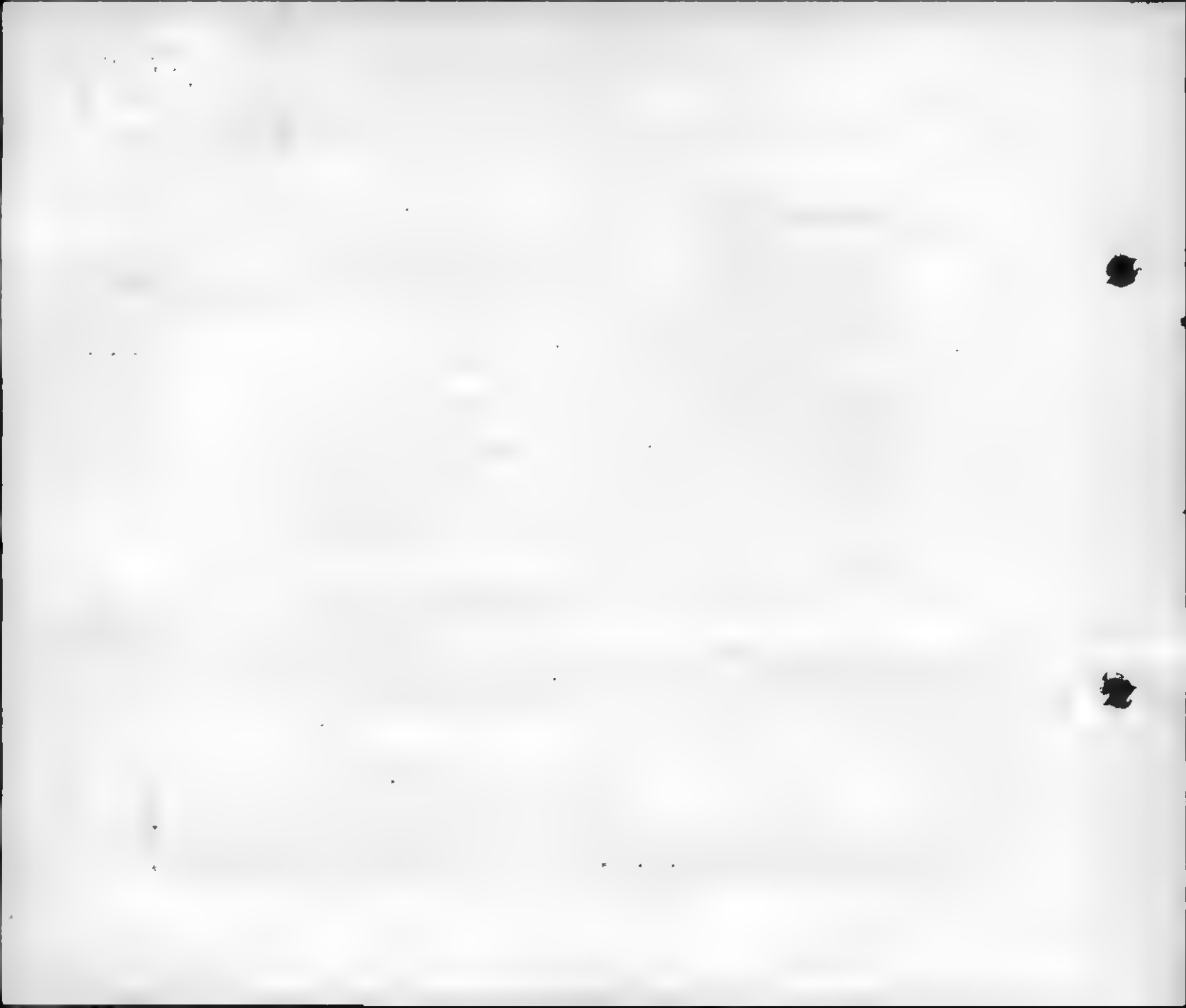
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>222 Pindell Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILBERT</b>		First <b>WILBERT</b>		Middle <b>Wells</b>		Last <b>Wells</b>		4. DATE OF DEATH Month <b>July</b>		Day <b>14</b>		Year <b>19 58</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-26-1935</b>		9. AGE (in years last birthday) <b>23</b> yrs		10. IF UNDER 1 YEAR Months <b>23</b>		11. IF UNDER 24 HRS Days <b>23</b>		Hours <b>23</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Monroville State Hosp.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Wells</b>		14. MOTHER'S MAIDEN NAME <b>Mary Edna Thomas</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes Korean War</b>		16. SOCIAL SECURITY NO			
17. INFORMANT <b>John Wells</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning.</b> 7:39.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>(c)</b> (c), stating the underlying cause lost DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(b)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Drowned while swimming.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year <b>7/13 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bende's Point</b>		20f. (City or town) (County) (State) <b>Annapolis Anne Arundel Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/14/58</b>							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-17-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fowlers Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Best State Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese #108 Wash. St. Annapolis Md.</b>		24a. REC'D BY REGISTRAR <b>Jul 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Reese</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







1

INSTRUCTIONS

**HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

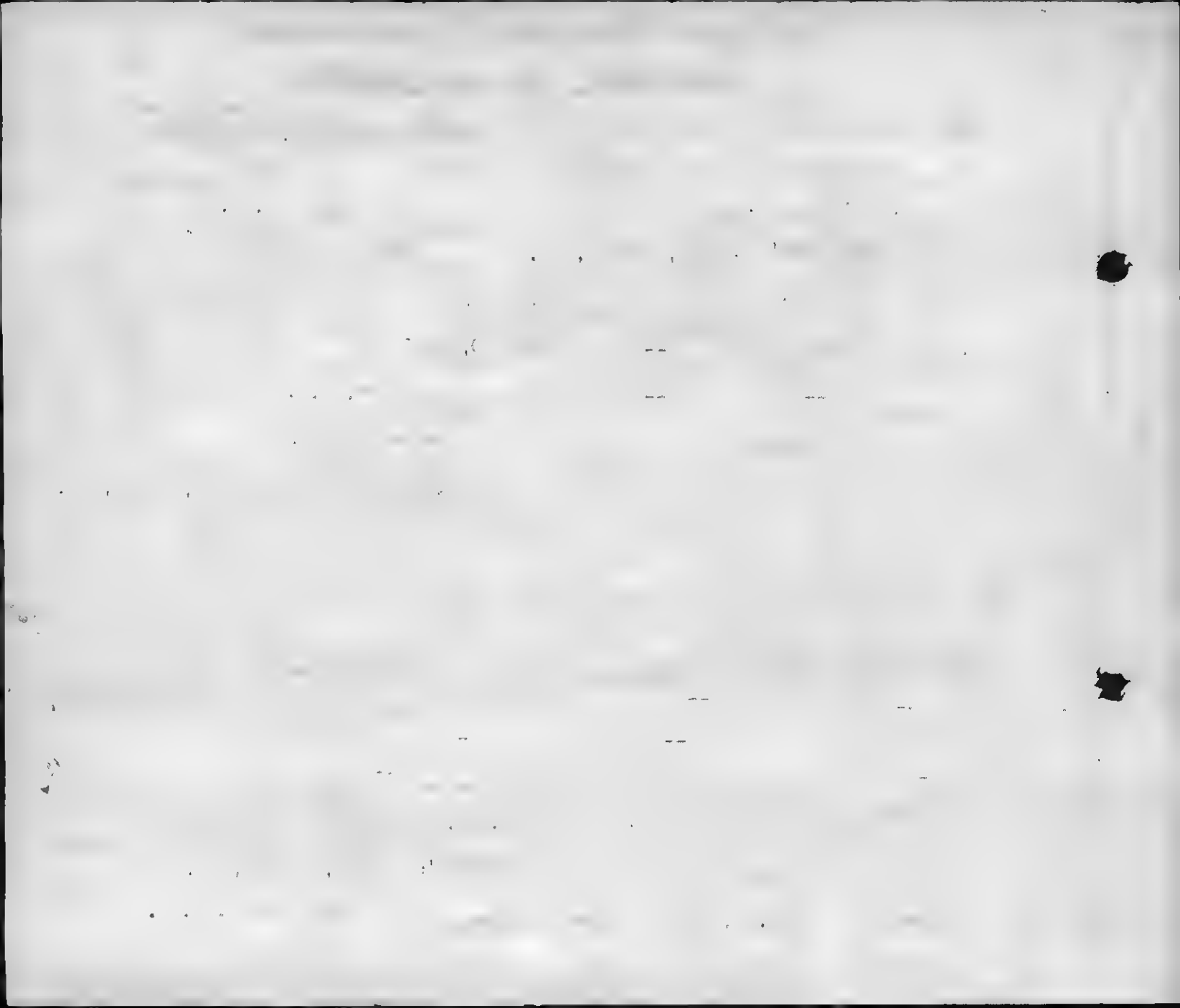
07601

7610

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		COUNTY		STATE	
CITY (If out of corporate limits, write RURAL and give nearest town) TOWN <u>Laurel, Maryland</u>		LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D. C.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D. C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Children's Center, Laurel, Md.</u>				STREET ADDRESS (If rural give location) <u>3536 Park Place NW</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Larry Williams</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>July 1 1958</u>			
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>--</u>	<b>8. DATE OF BIRTH</b> <u>March 20, 1957</u>	<b>9. AGE last birthday</b> <u>one</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>--</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>--</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anita Williams</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>--</u>		<b>16. SOCIAL SECURITY NO.</b> <u>--</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Social Service District Training School, Laurel, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>cardiovascular collapse</u>				INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>pneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>myocardial infarction</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>myocardial infarction</u>							
<b>19a. DATE OF OPERATION</b> <u>--</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>--</u>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u>--</u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u>--</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u>--</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>--</u>			
<b>22. I hereby certify that I attended the deceased from <u>6/6/58</u>, 19<u>58</u>, to <u>7/1/58</u>, 19<u>58</u>, that I last saw the deceased alive on <u>7/1/58</u>, 19<u>58</u>, and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>DATE SIGNED</b> <u>7/2/58</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>24. REC'D BY REGISTRAR</b> <u>Jul. 5, 1958</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Children's Center, Laurel, Md.</u>			
<b>26. DATE</b> <u>JUL 11 1958</u>				<b>27. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>			



## 7549 CERTIFICATE OF DEATH

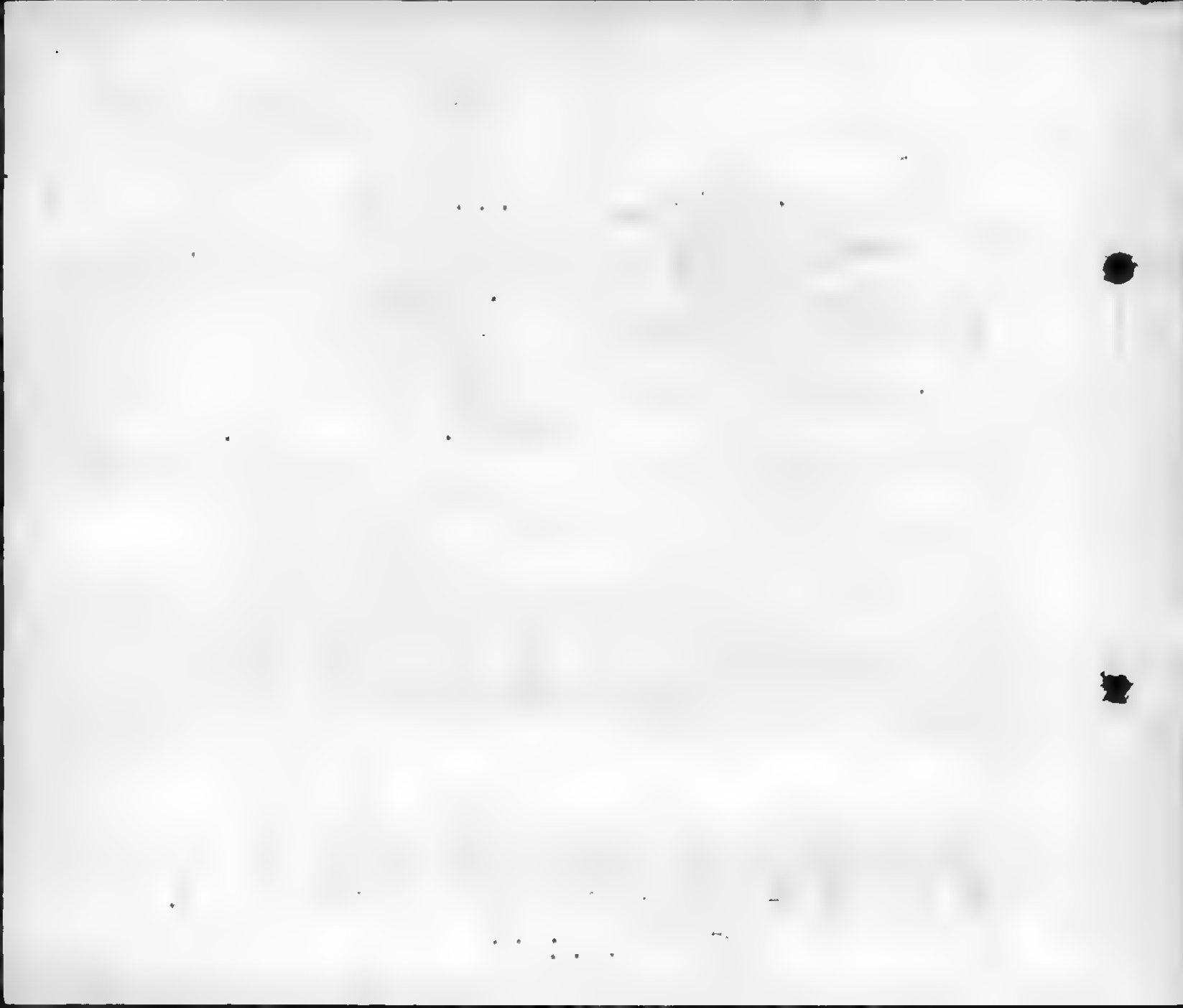
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel Gen. Hospital</b>				e. STREET ADDRESS <b>R.F.D. 3 Box 427</b>			
3. NAME OF DECEASED (Type or print) <b>ANNIE</b> First <b>BLANCHE</b> Middle <b>YOUNG</b> Last				4. DATE OF DEATH <b>July 16th.</b> Month <b>July</b> Day <b>16th.</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6th 1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>John R. Woodyard</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Thomason</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <b>Winfred D. Young</b> Address <b>Same # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gen Carcinomatous</b> 155.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ca large bowel</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7/5</b> , 19 <b>58</b> , to <b>7/16</b> , 19 <b>58</b> ; that I last saw the deceased alive on <b>7/16</b> , 19 <b>58</b> , and that death occurred at <b>11:26</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Annapolis, Md.</b> DATE SIGNED <b>7/16/58</b>							
ACTUAL SIGNATURE <b>S. Borssuck</b> M.D.				DATE SIGNED <b>7/16/58</b>			
PHYSICIAN'S NAME (Type) <b>S. Borssuck</b>				ADDRESS <b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18- 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b> ADDRESS <b>1661- Good Hope Rd. S.E. Washington 20, D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07603

7611

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edgewood Ave. High Point</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> <span style="float: right;">b. COUNTY <u>Buffalo</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buffalo</u> <span style="float: right;">69X-3 ✓</span> d. STREET ADDRESS <u>3952 Clinton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph Zajac Jr.</u> First Middle Last <b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1/7/35</u> <b>9. AGE</b> (In years last birthday) <u>23</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				<b>4. DATE OF DEATH</b> <u>July 13th</u> 19 <u>58</u> Month Day Year			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Buffalo, N.Y.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Joseph Zajac</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Never</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>John Zajac (Uncle)</u> <u>Buffalo, N.Y.</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u> <u>353.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert</u> <b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>7/13/58</u> <u>7/13/58</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>July 17, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Adalberts Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Cheestowaga, New York</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. SANDER &amp; SONS, INC.</u> <u>Baltimore, Md.</u> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <u>JUL 16 '58</u> DATE		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-503

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEATH CERT.



1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Cause of Death: \_\_\_\_\_

10. Manner of Death: \_\_\_\_\_

11. Signature of Medical Examiner: \_\_\_\_\_

12. Signature of Coroner: \_\_\_\_\_

13. Signature of Registrar: \_\_\_\_\_

14. Date of Filing: \_\_\_\_\_

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07604

7612

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL (SOLLEY)</u>		LENGTH OF STAY (in this place) <u>33 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL (SOLLEY)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>216 WERNER RD.</u>				STREET ADDRESS (If rural give location) <u>216 WERNER ROAD</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOSEPH</u> <u>ZAMOSTNY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY</u> <u>1</u> <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MARCH 31, 1888</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAILING COMMISSION</u>		11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ZAMOSTNY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA KULISHEK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 10 7664</u>		17. INFORMANT & ADDRESS <u>FRANK ZAMOSTNY - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A) <u>CARCINOMA STOMACH</u>						<u>1 YEAR</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4/17/58</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA STOMACH WITH METASTASES</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN</u> , 19 <u>58</u> , to <u>JULY 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city, town, state) <u>M.D. RIVIERA BEACH MD</u>		DATE SIGNED <u>7/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>7-1-58</u>		NAME OF CEMETERY OR CREMATORY <u>Eden Hill</u>		LOCATION (City, town, or county) (State) <u>Balto.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>JUL 2 '58</u>							

# CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF MARRIED

NAME OF FATHER

NAME OF MOTHER

NAME OF SISTER

NAME OF BROTHER

NAME OF NEPHEW

NAME OF Nephew

NAME OF Nephew

NAME OF Nephew

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INVESTIGATION

INVESTIGATION